

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

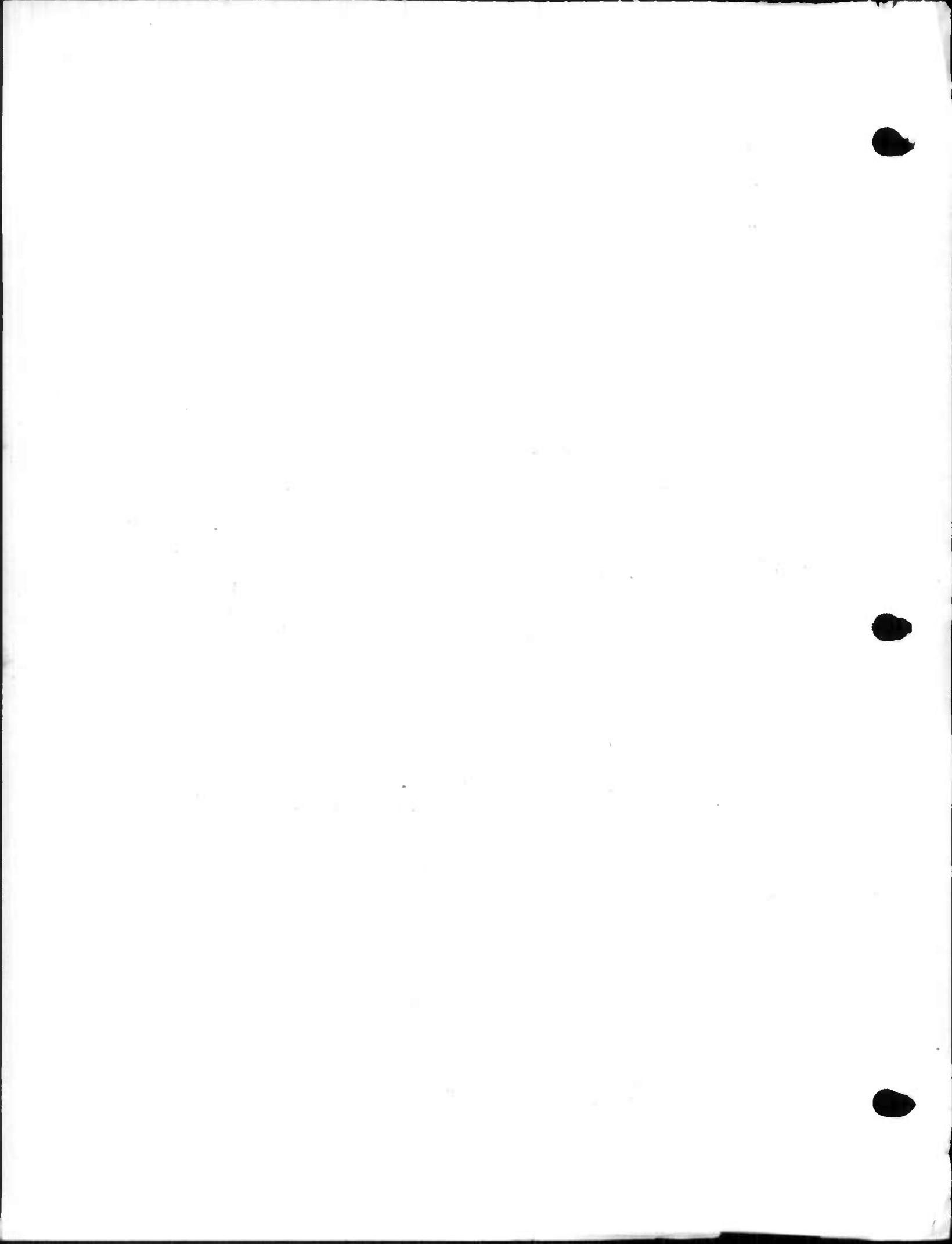
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		Floyd E Elmer Elower				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH p.m.					
4. SOCIAL SECURITY NUMBER 212-14-7771		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 15, 1907		8. BIRTHPLACE (State or Foreign Country) Maryland			
9e. FACILITY NAME (If not institution, give street and number) St. Catherines Nursing Center		9b. CITY, TOWN OR LOCATION OF DEATH Emmitsburg				9c. COUNTY OF DEATH Frederick							
RESIDENCE OF DECEASED													
10e. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Thurmont				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 124 E. Main St.				10f. ZIP CODE 21788				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16e. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer Technician				16b. KIND OF BUSINESS/INDUSTRY U.S. Government							
17. FATHER'S NAME (First, Middle, Last) charles J. Elower				18. MOTHER'S NAME (First, Middle, Maiden Surname) Byrde M. Delphy									
19e. INFORMANT'S NAME (Type/Print) Donald W. Elower				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 124 E. Main St./Thurmont, Md. 21788									
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Cem.				DATE 6-13	20c. LOCATION — City or Town, State Frederick, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond Peterson</i>				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home									
104 E. Main St./ Thurmont, Md. 21788													
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cancer of Bladder with Metastases</i>													
Approximate interval between onset and death													
a. DUE TO (OR AS A CONSEQUENCE OF):													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus / Aortic Aneurysm Osteoarthritis / Peripheral Neuropathy</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. DATE SIGNED (Month, Day, Year) ► 6/19/95											
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Alan Carroll, M.D.</i>		29c. LICENSE NUMBER 0187 05											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
Dr. Alan Carroll, M.D. / S. Seton Ave./ Emmitsburg, Md.		31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE <i>John Davidson, R.R.C.</i>									



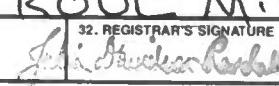
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

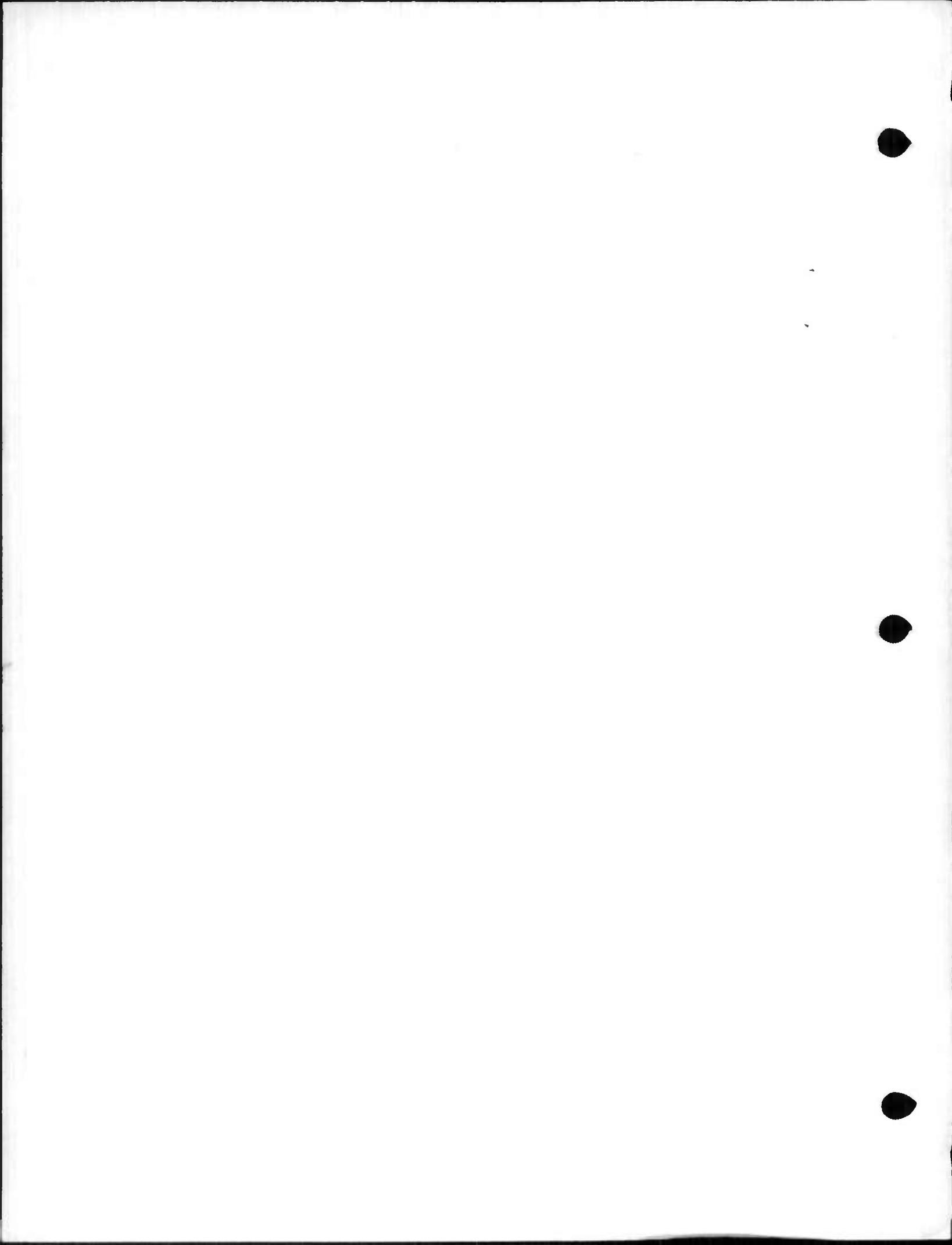
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) GRACE I ECKARD										2. DATE OF DEATH MONTH DAY YEAR 05 21 95	3. TIME OF DEATH HRS. MIN. 10:05 M
4. SOCIAL SECURITY NUMBER 577-84-1200		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. 88	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 1/25/07	8. BIRTHPLACE (State or Foreign Country) Gallitzin, PA				
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital Center										9b. CITY, TOWN OR LOCATION OF DEATH Clinton	9c. COUNTY OF DEATH Prince George's
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Ft. Washington			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 6804 Bock Road	10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY n/a			16c. DATE 5/31/95			
17. FATHER'S NAME (First, Middle, Last) Samuel Wolfe										18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Kunsman	
19a. INFORMANT'S NAME (Type/Print) Susan Bianchini										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 718 Montgomery St., Hollidaysburg, PA 16648	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenlawn Cemetery			20c. LOCATION — City or Town, State Hollidaysburg, PA						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Plank, Stitt, & Stevens Funeral Home 421 Montgomery St., Hollidaysburg, PA 16648	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death	
<p>a. Metastatic Carcinoma DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Carcinoma of Colon DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. Pulmonary Fibrosis DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. </p>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pulmonary Fibrosis										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Michael M.D.		29c. LICENSE NUMBER D24020		29d. DATE SIGNED (Month, Day, Year) 5/27/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NOT L KOUL M.D. 3710 River St, Temple Hills, MD											
31. DATE FILED (Month, Day, Year) JUN 23 1995		32. REGISTRAR'S SIGNATURE 									

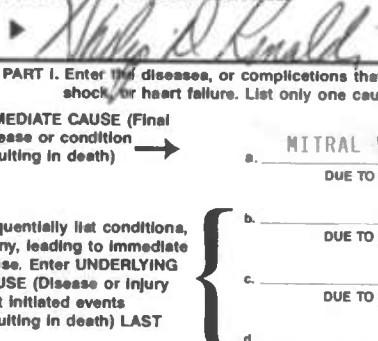
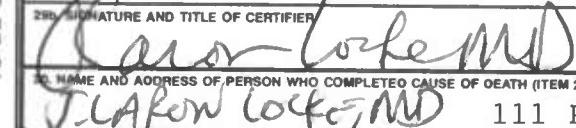
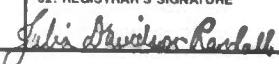


95 19003

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/29/95 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
		DECEASED'S NAME (First, Middle, Last)					DATE OF DEATH		TIME OF DEATH										
		JESTINA FAULKNER					MONTH MAY 30 1995		4:00 P M										
1. DECEASED'S NAME (First, Middle, Last)		4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)					
		218-11-5850		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		37 YRS.		MONTH		DAYS		HOURS		MIN.		Jan. 16, 1958 West Africa			
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH					9c. COUNTY OF DEATH												
LAUREL REGIONAL HOSPITAL		LAUREL					PRINCE GEORGES												
RESIDENCE OF DECEASED		10c. CITY, TOWN OR LOCATION																	
10e. STATE Maryland		10b. COUNTY Prince George's		Calverton															
10e. STREET AND NUMBER 12163 Beltsville Drive		10f. ZIP CODE 20705					10g. CITIZEN OF WHAT COUNTRY? USA												
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black													
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4		16b. KIHO OF BUSINESS/INDUSTRY Administrative Coordinator		16c. KIHO OF BUSINESS/INDUSTRY Holy Cross Hospital													
17. FATHER'S NAME (First, Middle, Last) Arnold Faulkner		18. MOTHER'S NAME (First, Middle, Maiden Surname) Eudora Williams																	
19a. INFORMANT'S NAME (Type/Print) Kenneth A. Faulkner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1425 Prince Avenue, Athens, Georgia 30606																	
20. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Gate of Heaven Cemetery		DATE 6/3		20c. LOCATION — City or Town, State Silver Spring, Maryland													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904																	
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. MITRAL VALVE PROLAPSE																			
DUE TO (OR AS A CONSEQUENCE OF):																			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. d.																			
DUE TO (OR AS A CONSEQUENCE OF):																			
DUE TO (OR AS A CONSEQUENCE OF):																			
d.																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)																	
		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED											
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) ► MAY 31, 1995					
29b. SIGNATURE AND TITLE OF CERTIFIER 																			
31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T. Karen Locke, MD		111 PENN STREET, BALTIMORE, BALTIMORE 21201																	
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 																	

BALTIMORE, MARYLAND 21215-0020

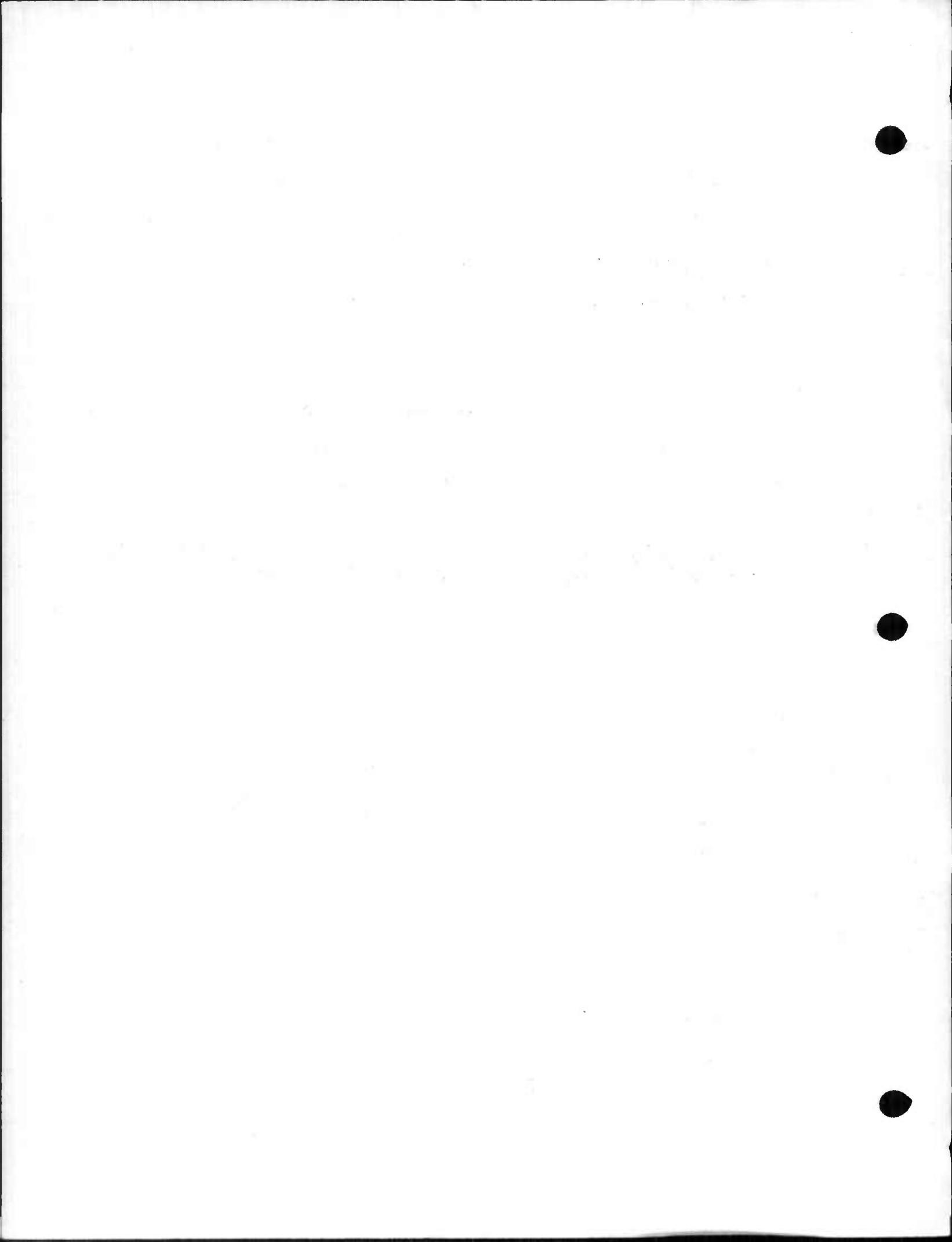
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



95 19004

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

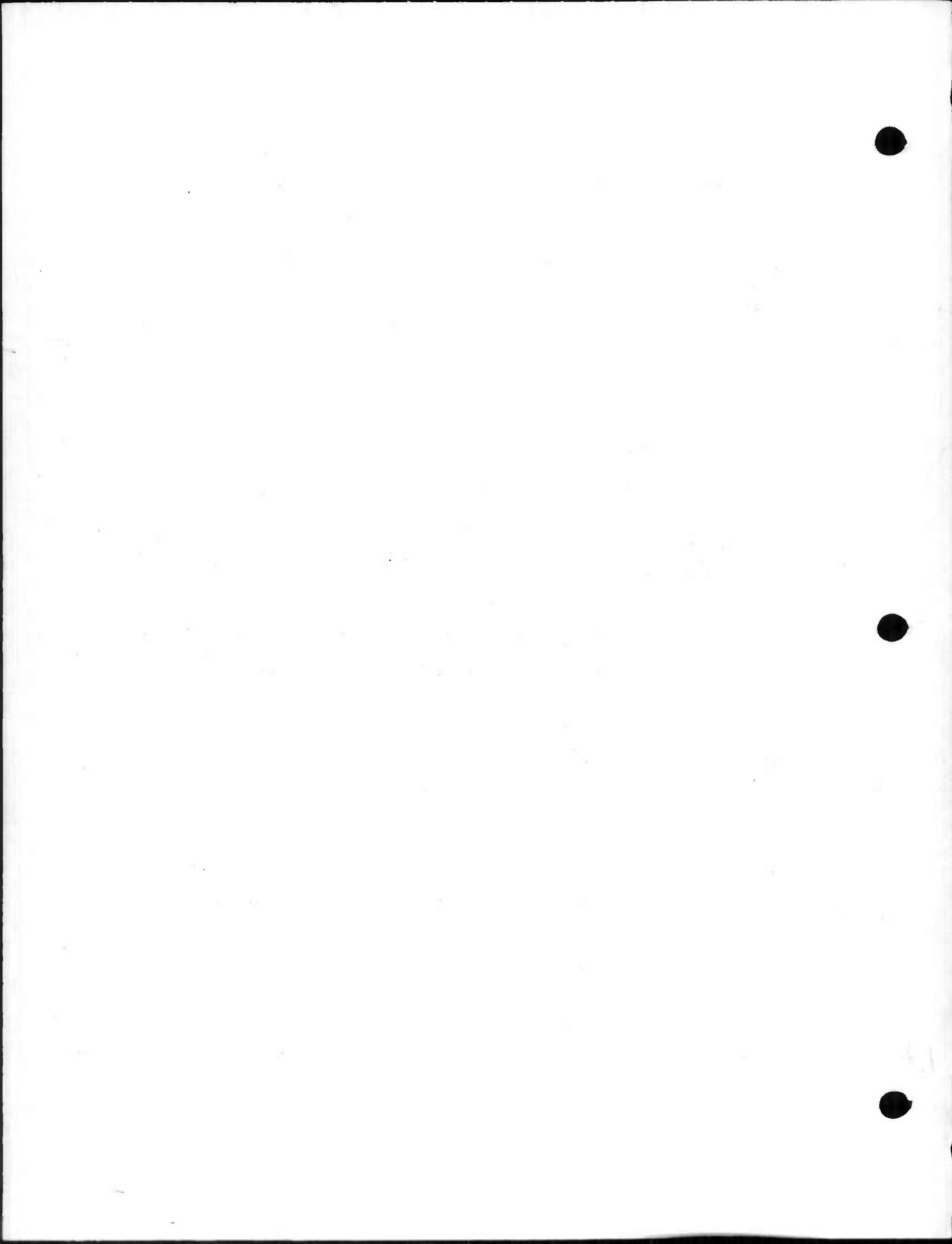
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - DECEDENT'S NAME (First, Middle, Last)		TOWNSEND BAER FRIEDMAN, JR.								2. DATE OF DEATH MONTH JUNE DAY 03 YEAR 1995	3. TIME OF DEATH 1906 M
4. SOCIAL SECURITY NUMBER 318-32-3701		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 55 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS				7. DATE OF BIRTH (Month, Day, Year) Jan. 4, 1940	8. BIRTNPLACE (State or Foreign Country) Illinois
9a. FACILITY NAME (If not institution, give street and number) SWAINS LOCK C & O CANAL		9b. CITY, TOWN OR LOCATION OF DEATH POTOMAC								9c. COUNTY OF DEATH MONTGOMERY	
10e. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1412 Kersey Lane		10f. ZIP CODE 20854						10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5+		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White						14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+ Foreign Service Officer		16b. KIND OF BUSINESS/INDUSTRY U.S. Department of State							
17. FATHER'S NAME (First, Middle, Last) Townsend Baer Friedman		18. MOTHER'S NAME (First, Middle, Maiden Surname) Corinne Neuberger									
19a. INFORMANT'S NAME (Type/Print) Eli Prata Friedman		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1412 Kersey Lane, Rockville, Maryland 20854									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) ► Michael L. Siegan		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael L. Siegan		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501									
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Approximate Interval Between Onset and Death									
a. <u>HYPERTENSIVE ATHEROSCLEROTIC CARDIOVASCULAR</u> DUE TO (OR AS A CONSEQUENCE OF):											
{ b. <u>Disease Complicated By Drowning</u> DUE TO (OR AS A CONSEQUENCE OF):											
c. <u></u> DUE TO (OR AS A CONSEQUENCE OF):											
d. <u></u>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) 6 395		28b. TIME OF INJURY 7 5 M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED Found in muddy water					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) water									
29b. SIGNATURE AND TITLE OF CERTIFIER Robert A. Pumphrey		29c. LICENSE NUMBER O.C.M.E.						29d. DATE SIGNED (Month, Day, Year) ► JUNE 04, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert A. Pumphrey 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE John Shuler Marshall									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

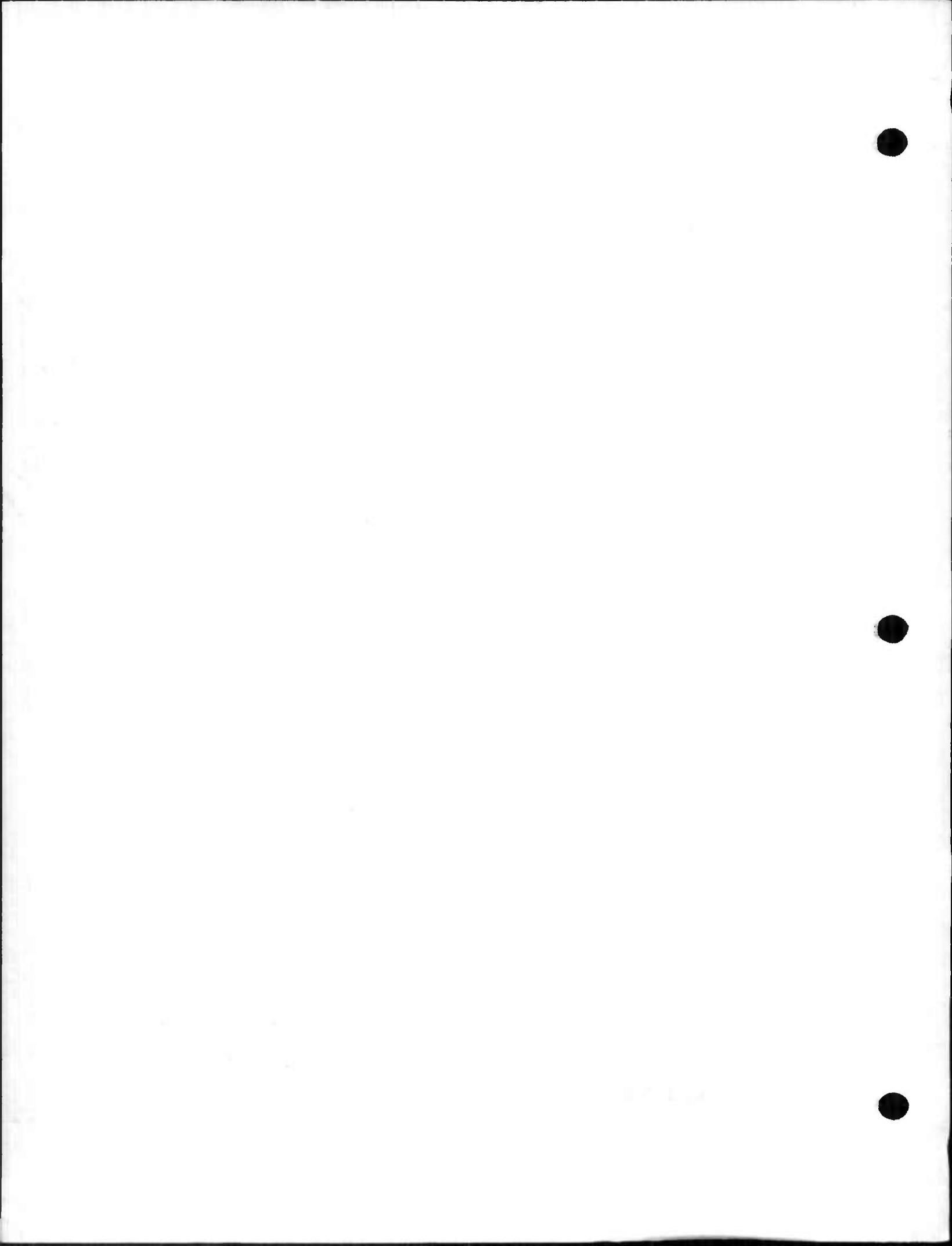
6

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19005

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
JAMES CHARLES FIELDS						MAY 24 1995	12:15 PM
4. SOCIAL SECURITY NUMBER 236-20-9946		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 7, 1910	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	
9c. COUNTY OF DEATH Allegany						9d. BIRTHPLACE (State or Foreign Country) West Virginia	
10a. STATE WV		10b. COUNTY Hampshire		10c. CITY, TOWN OR LOCATION Springfield			
10e. STREET AND NUMBER P. O. Box 1				10f. ZIP CODE 26763		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer			16b. KIND OF BUSINESS/INDUSTRY Farm		
17. FATHER'S NAME (First, Middle, Last) Charles H. Fields				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Kincaid			
19a. INFORMANT'S NAME (Type/Print) Vallie V. Fields				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 1, Springfield, WV 26763			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) OMPS Cremation Service				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE		20c. LOCATION — City or Town, State Winchester, VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Endstage Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): 3 mos</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>b. Severe Myodystrophy DUE TO (OR AS A CONSEQUENCE OF): 2 yrs</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): </p> <p>d. DUE TO (OR AS A CONSEQUENCE OF): </p>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED	
						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER 					
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D22181					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		29d. DATE SIGNED (Month, Day, Year) MAY 24, 1995					
DR. GARY WAGONER, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502		31. DATE FILED (Month, Day, Year) JUN 05 1995					
32. REGISTRAR'S SIGNATURE 							



95 19006

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROY W. FAGAN												2. DATE OF DEATH MONTH JUNE DAY 3 YEAR 1995	3. TIME OF DEATH 1:40 P.M.
4. SOCIAL SECURITY NUMBER 195-07-4098			5. SEX M	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) MAY 31, 1907				8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number) NATIONAL LUTHERAN HOME					9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE				9c. COUNTY OF DEATH MONTGOMERY CO.				
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE MD.		10b. COUNTY CARROLL CO.		10c. CITY, TOWN OR LOCATION MT. AIRY				10f. ZIP CODE 21771				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EMPLOYEE				16b. KIND OF BUSINESS/INDUSTRY BUS CO., HARRISBURG, PA.						
17. FATHER'S NAME (First, Middle, Last) JOHN A. FAGAN					18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA C. STONER								
19a. INFORMANT'S NAME (Type/Print) REV. DR. REICHARD					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9701- VEIRS DRIVE, ROCKVILLE, MD. 20850								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAPEL CEMETERY				DATE 6/6	20c. LOCATION — City or Town, State LIBERTYTOWN, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.M. Hyson					22. NAME AND ADDRESS OF FACILITY HYSONG CO., INC. 1300- N STREET, N.W., WASH., DC								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardio pulmonary arrest.</i> probable myocardial infarction Severe left ventricular dysfunction.													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Chronic obstructive lung disease</i> <i>congestive heart failure - stable</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></i>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. CHARLES W. KARESH, MD MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29d. DATE SIGNED (Month, Day, Year) JUNE 4/95	
29b. SIGNATURE AND TITLE OF CERTIFIER Charles W. Kares, MD					29c. LICENSE NUMBER D21726								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CHARLES KARESH - 9701- VEIRS DR., ROCKVILLE, MD. 20850													
31. DATE FILED (Month, Day, Year) JUN 07 1995			32. REGISTRAR'S SIGNATURE John Andrew Redell										

BALTIMORE, MARYLAND 21215-0020

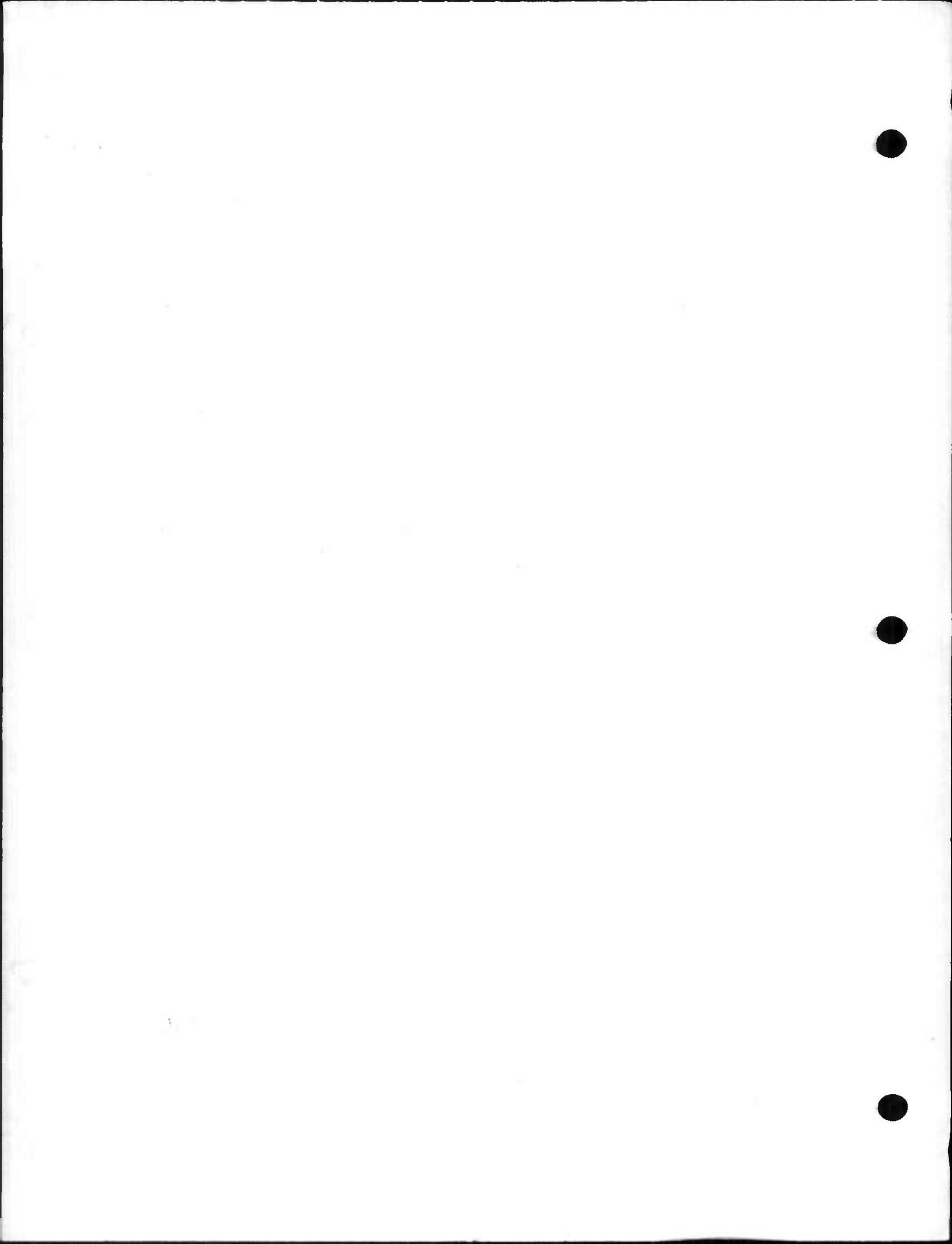
TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

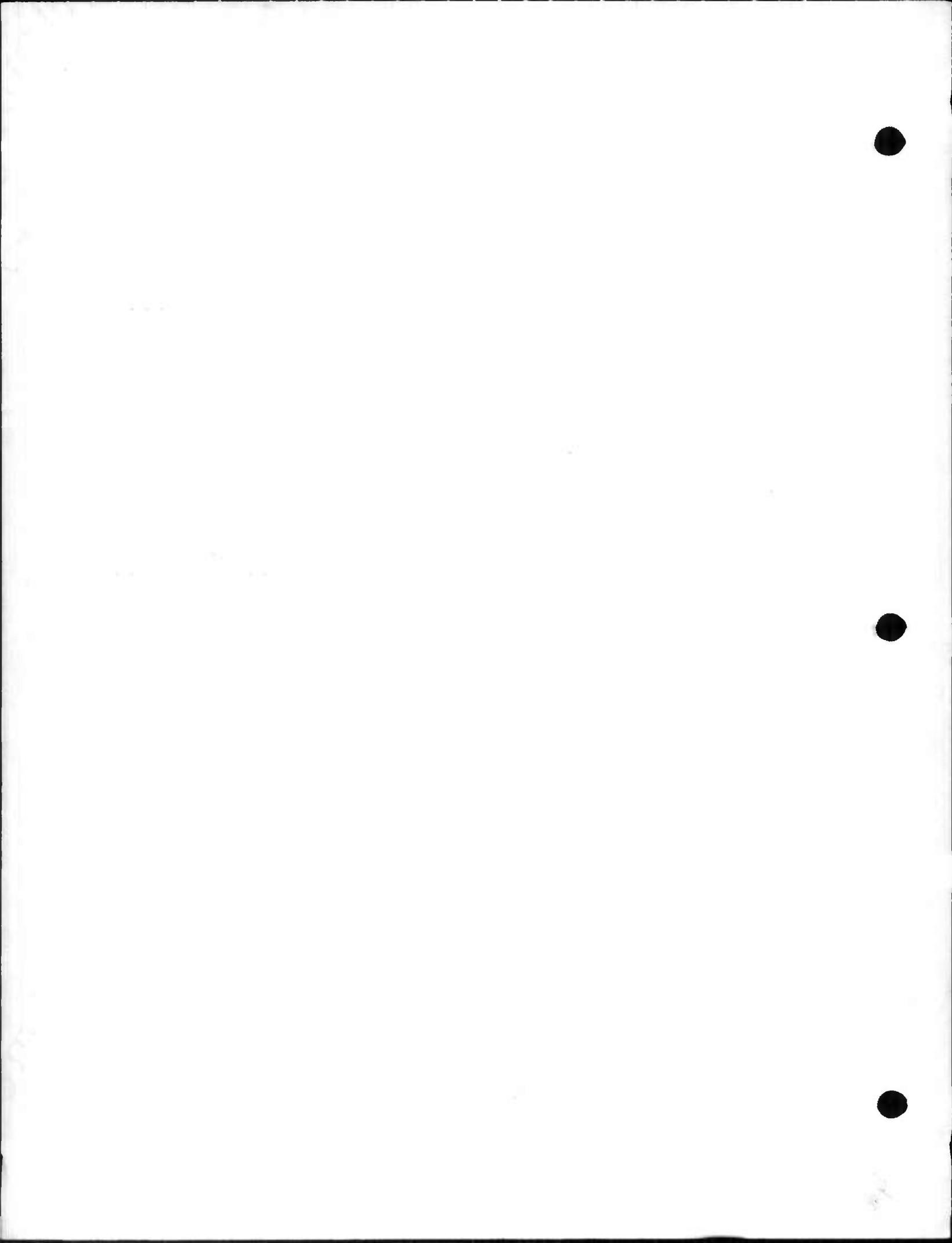
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		MARY FLETCHER						2. DATE OF DEATH MONTH JUNE DAY 1 YEAR 1995		3. TIME OF DEATH 6:17 AM	
4. SOCIAL SECURITY NUMBER 216-12-4093		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		7. DATE OF BIRTH (Month, Day, Year) January 19, 1922		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Cheverly						9c. COUNTY OF DEATH Prince George's			
10a. STATE Maryland		10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Landover						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 7110 Columbia Park Road		10f. ZIP CODE 20785						10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse Assistant		16b. KIND OF BUSINESS/INDUSTRY Glendale (Retired)							
17. FATHER'S NAME (First, Middle, Last) Thomas Jackson, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Ennis									
19a. INFORMANT'S NAME (Type/Print) Mr. Arthur Fletcher (Husband)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7110 Columbia Park Road Landover, Maryland 20785									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Resurrection Cemetery		DATE June 5, 1995		20c. LOCATION — City or Town, State Clinton, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENCIATE 		22. NAME AND ADDRESS OF FACILITY Rollins Funeral Home, Inc. 4339 Hunt Place, N.E. Washington, D.C. 20019									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>b. <i>cardio respiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>b. <i>probable myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>acute renal failure post aortic aneurysm resection (emergency)</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>										5/26 5/26	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>acute renal failure post aortic aneurysm resection (emergency)</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D18189									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Bruce Lourman MD</i>		29d. DATE SIGNED (Month, Day, Year) ► 6/1/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRUCE LOURMAN MD		32. REGISTRAR'S SIGNATURE <i>Jahn Davidson Randall</i>									
31. DATE FILED (Month, Day, Year) JUN 07 1995											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

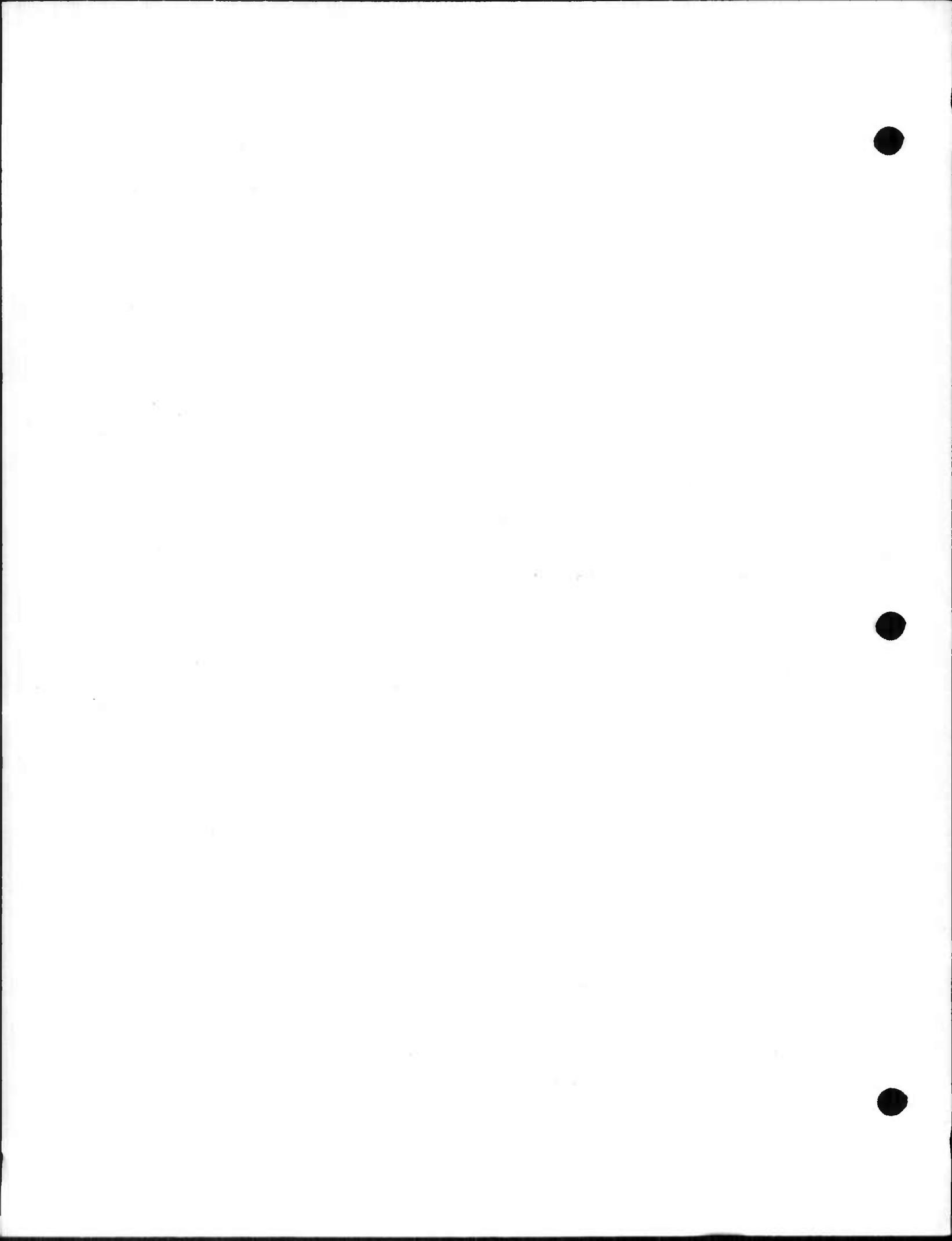
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH YEAR
Elmer Frey, Jr.												June 2, 1995	2015 M
4. SOCIAL SECURITY NUMBER 137-01-9839		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 10, 1914		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 403 Park Place		9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil									
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Cecil	10c. CITY, TOWN OR LOCATION Elkton								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 403 Park Place				10f. ZIP CODE 21921				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 2 Millwright			16b. KIND OF BUSINESS/INDUSTRY Cork Company							
17. FATHER'S NAME (First, Middle, Last) Elmer Frey					18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Jane Reese								
19a. INFORMANT'S NAME (Type/Print) Alberta S. Frey					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 Park Place - Elkton, MD 21921								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gilpin Manor Memorial Park			20c. LOCATION — City or Town, State Elkton, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Doris L. Hicks</i>			22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Bilateral Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Refractory Anemia with Excess Blast</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER <i>C10000 2768</i>										29d. DATE SIGNED (Month, Day, Year) ► <i>6/6/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martha Hosford, M.D. - 111 West High Street - Elkton, MD 21921													
31. DATE FILED (Month, Day, Year) <i>JUN 07 1995</i>		32. REGISTRAR'S SIGNATURE <i>Jahn Shuckler-Lindell</i>											

95 19008



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

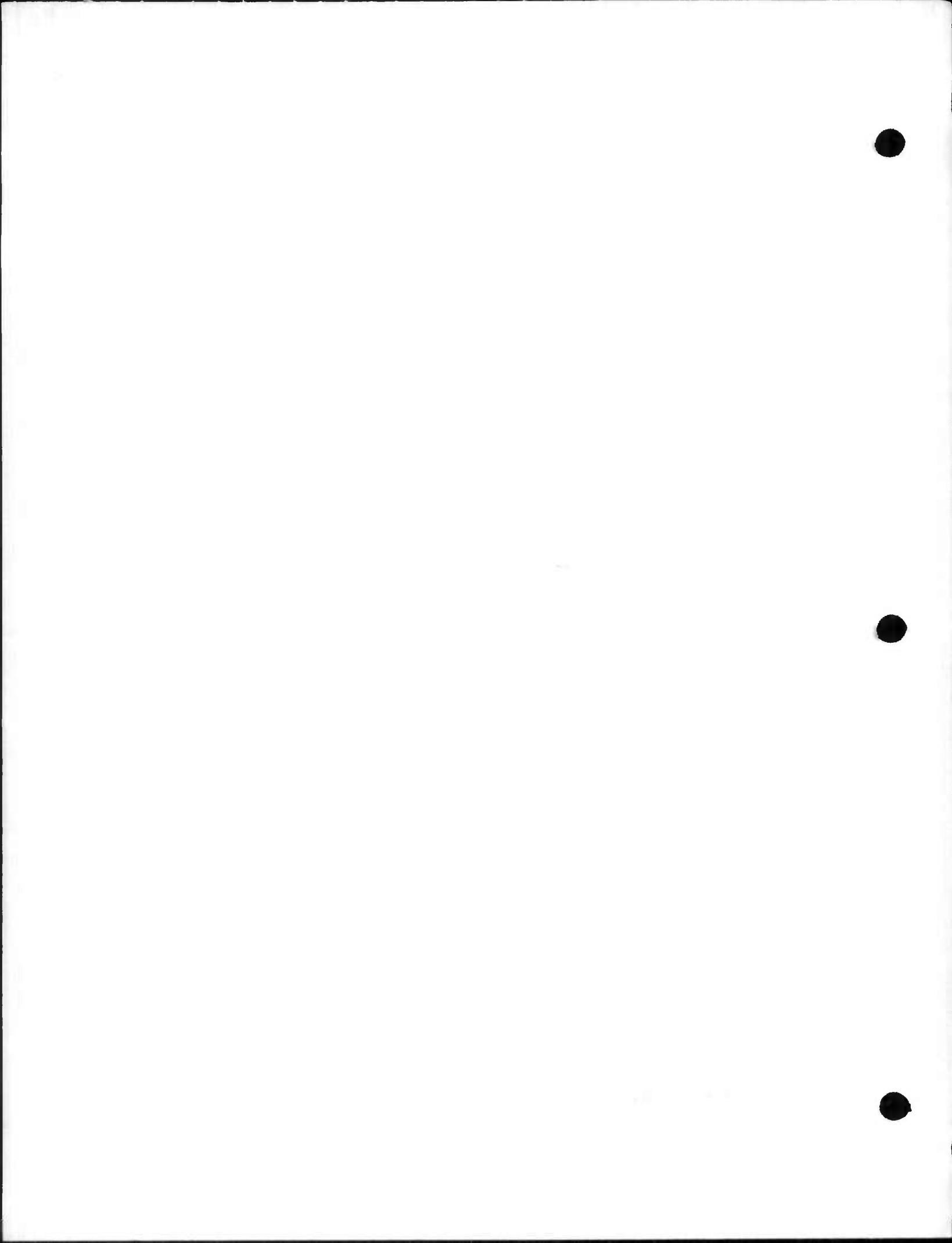
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last) Thomas Frederick FLEMING													
4. SOCIAL SECURITY NUMBER 219-05-2704		5. SEX 1 X M 2 □ F		6. AGE (In yrs. last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2. DATE OF DEATH MONTH JUN DAY 9 YEAR 1995		3. TIME OF DEATH 3:00 AM	
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center											7. DATE OF BIRTH (Month, Day, Year) Nov. 13, 1909	8. BIRTHPLACE (State or Foreign Country) Maryland	
9b. CITY, TOWN OR LOCATION OF DEATH Frederick											9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEASED													
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick								10d. INSIDE CITY LIMITS? 1 X YES 2 □ NO	
10e. STREET AND NUMBER 501 Biggs Avenue						10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Barber				16b. KIND OF BUSINESS/INDUSTRY Hair cutting - Barbering					
17. FATHER'S NAME (First, Middle, Last) John William Fleming						18. MOTHER'S NAME (First, Middle, Maiden Surname) Alberta Shipley							
19a. INFORMANT'S NAME (Type/Print) Mrs. Margaret B. Fleming				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 501 Biggs Ave., Frederick, Md. 21701									
20a. METHOD OF DISPOSITION 1 □ Burial 2 X Cremation 3 □ Removal from State 4 X Donation 5 □ Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Olivet Cemetery				20c. LOCATION — City or Town, State June 13, 1995 Frederick, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Rubel O. Basford				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701									
23. PART I. Enter the deceases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Failure</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> b. <i>Pneumonia</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> c. <i>CVA</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Prostate Cancer.</i>												24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 X Outpatient DOA: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)									
27. MANNER OF DEATH 1 □ Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 7 □ Homicide 4 □ Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 X NO		28d. DESCRIBE HOW INJURY OCCURED			
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Casagrande</i>				29c. LICENSE NUMBER D 40307				29d. DATE SIGNED (Month, Day, Year) ► June 9, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Eugene B. Casagrande MD 1564 Opossumtown Pike, Frederick, Md. 21702													
31. DATE FILED (Month, Day, Year) JUN 12 1995				32. REGISTRAR'S SIGNATURE <i>Jane A. Shuckar Harrell</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

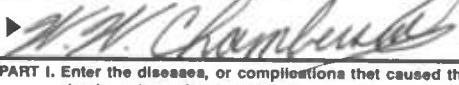
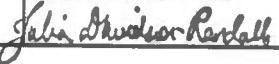
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

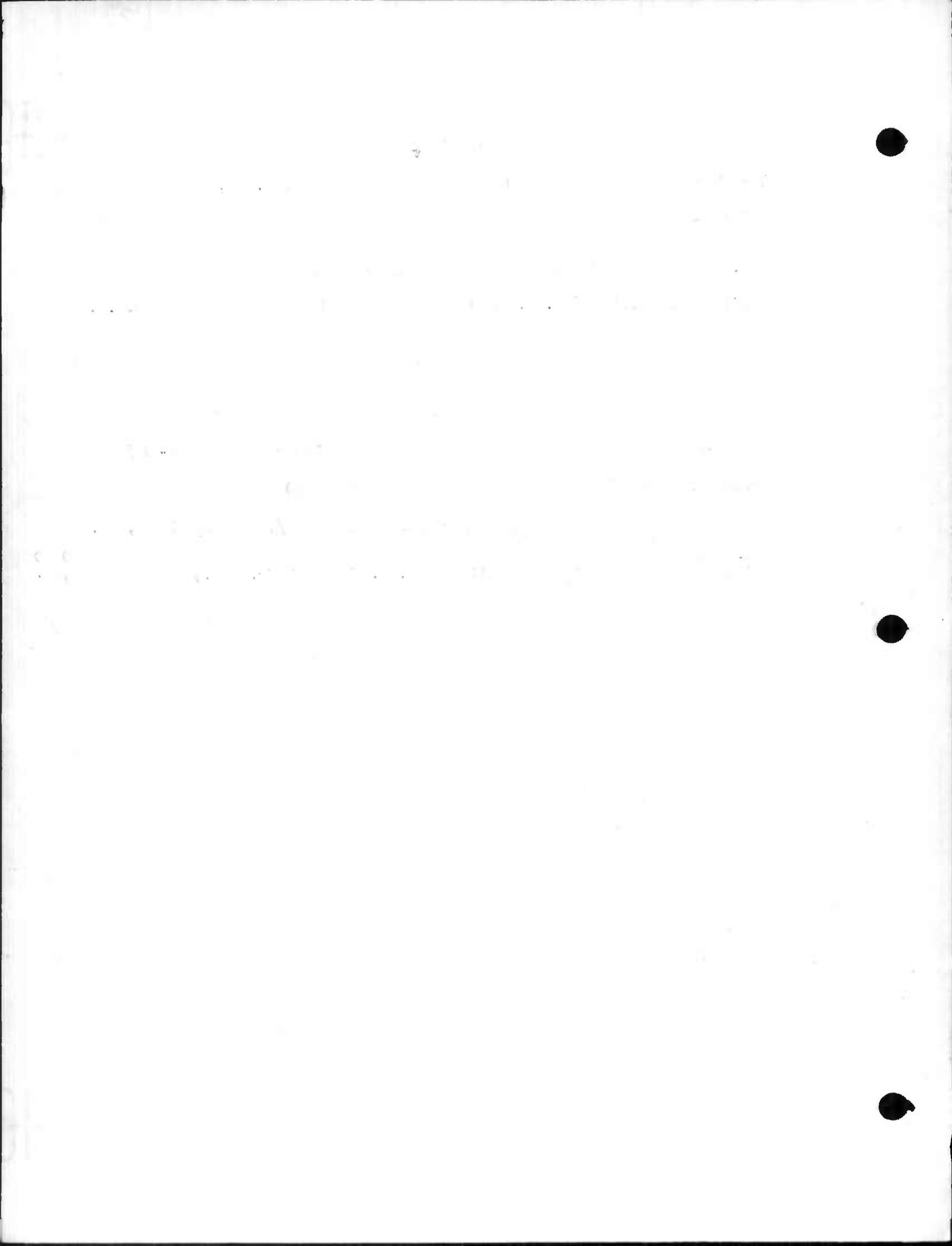
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) MADELINE GRUSKIN								2. DATE OF DEATH MONTH JUNE DAY 7 , YEAR 1995	3. TIME OF DEATH 4:15 A.M.	
4. SOCIAL SECURITY NUMBER 579-30-9514		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH (Month, Day, Year) FEB. 22, 1915		8. BIRTHPLACE (State or Foreign Country) NEW YORK
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA							9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEDENT										
10a. STATE MD.	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION SILVER SPRING							10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1135 UNIVERSITY BLVD. W. #610				10f. ZIP CODE 20902			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			18b. KIND OF BUSINESS/INDUSTRY AT HOME					
17. FATHER'S NAME (First, Middle, Last) LAZAR PAVES				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH ANDRUSIER						
19a. INFORMANT'S NAME (Type/Print) MITCHELL GRUSKIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY			DATE 6/7	20c. LOCATION — City or Town, State RIVERDALE, MD.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD.						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										
a. ACUTE AORTIC OCCLUSION DUE TO (OR AS A CONSEQUENCE OF): b. GASTRO INTESTINAL BLEED DUE TO (OR AS A CONSEQUENCE OF): c. INFLAMMATORY BOWEL DISEASE DUE TO (OR AS A CONSEQUENCE OF): d. _____										
Approximate Interval Between Onset and Death 2 DAYS WEEKS YEARS										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HEMOLYTIC ANEMIA INFLAMMATORY BOWEL DISEASE										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER P-TALWAR, M.D.				29c. LICENSE NUMBER D 36552			29d. DATE SIGNED (Month, Day, Year) JUNE 7 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P-TALWAR, 6121 MONTROSE RD. ROCKVILLE MD. 20852										
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE 								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

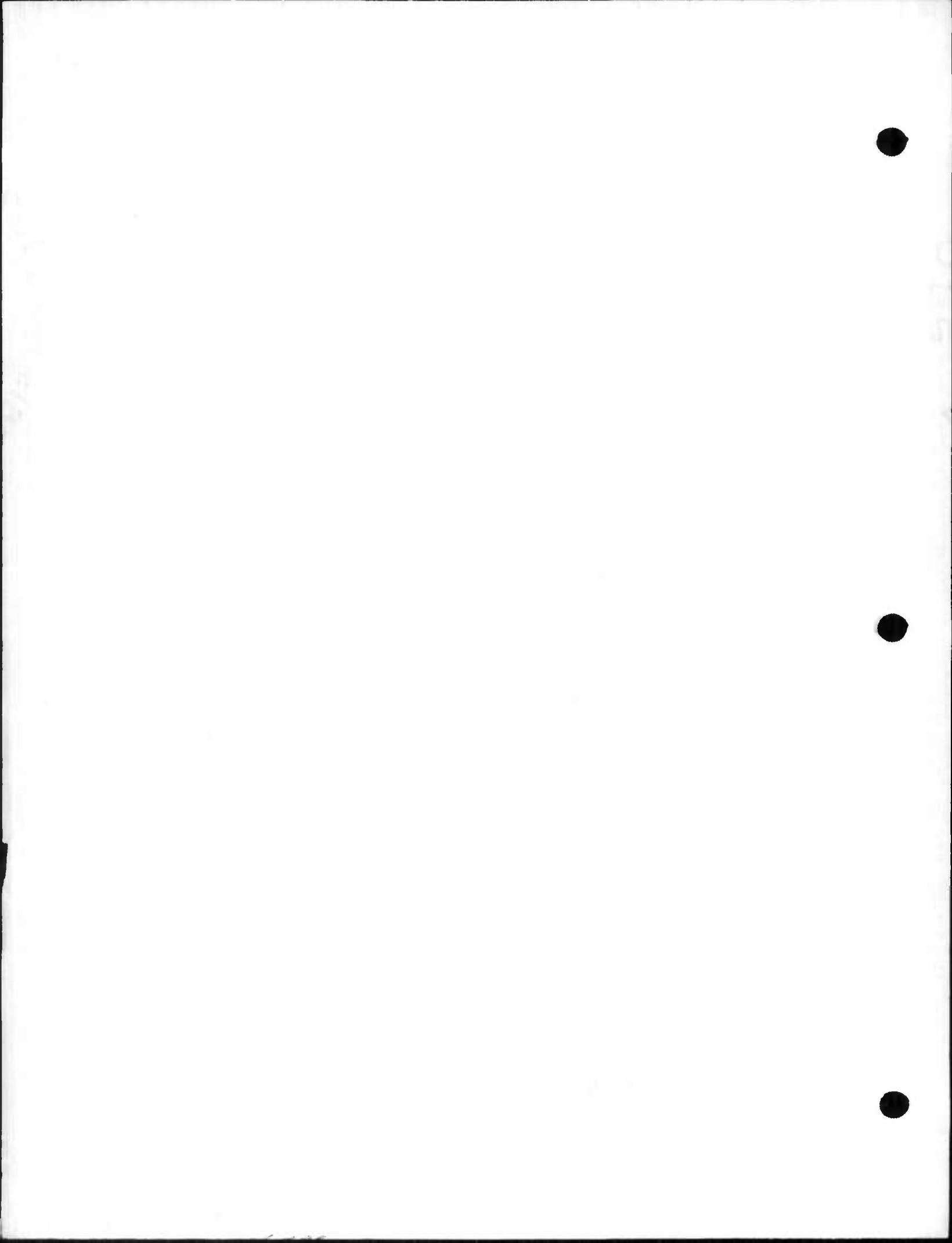
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last) Murray Gottlieb										2. DATE OF DEATH MONTH 8 DAY 2 YEAR 95			
4. SOCIAL SECURITY NUMBER 054-20-3937		5. SEX 1 X M 2 □ F		6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		3. TIME OF DEATH M			
9a. FACILITY NAME (If not institution, give street and number) 2607 LOMA STREET										7. DATE OF BIRTH (Month, Day, Year) FEB. 28, 1925			
9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING										8. BIRTHPLACE (State or Foreign Country) NEW YORK			
9c. COUNTY OF DEATH MONTGOMERY													
RESIDENCE OF DECEDENT													
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING								10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO	
10e. STREET AND NUMBER 2607 LOMA STREET										10f. ZIP CODE 20902		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) EXHIBIT SPECIALIST				16b. KIND OF BUSINESS/INDUSTRY DEPARTMENT OF LABOR							
17. FATHER'S NAME (First, Middle, Last) HARRY GOTTLIEB										18. MOTHER'S NAME (First, Middle, Maiden Surname) GOLDIE LEVY			
19e. INFORMANT'S NAME (Type/Print) ROSALIE GOTTLIEB (WIFE)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2607 LOMA STREET - SILVER SPRING, MARYLAND 20902								
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery, name of funeral home, etc.) MT. LEBANON CEMETERY				DATE 6/6		20c. LOCATION — City or Town, State ADELPHI, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Rosalie A. Howell</i>					22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS 1170 ROCKVILLE PIKE - ROCKVILLE, MARYLAND								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Severe Coronary Heart Disease Approximate Interval Between Onset and Death DUE TO (OR AS A CONSEQUENCE OF): years b. Advanced Atherosclerosis years DUE TO (OR AS A CONSEQUENCE OF): c. Biventricular Heart Failure years DUE TO (OR AS A CONSEQUENCE OF): d. Extensive Anterior Myocardial Infarction years													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN X													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)											
27. MANNER OF DEATH 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Herman B. Howell</i>											
29c. MEDICAL EXAMINER: On the basis of examination and investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 25 808		29d. DATE SIGNED (Month, Day, Year) ► 6/2/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10313 Georgia Ave Silver Spring Maryland 20902		32. REGISTRAR'S SIGNATURE <i>Juli Shuler-Randall</i>											
31. DATE FILED (Month, Day, Year) JUN 07 1995													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

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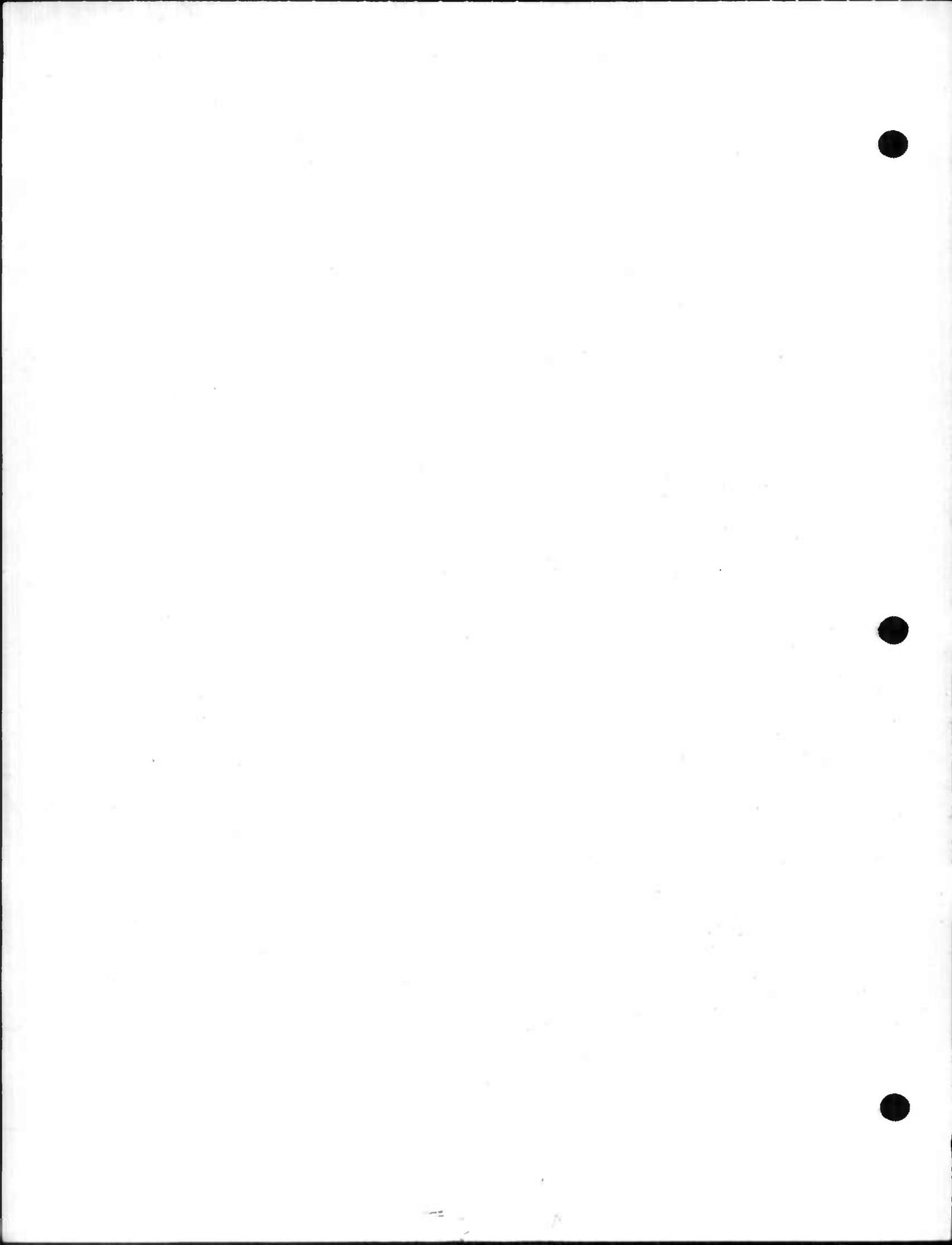
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last)			Herbert R. Granville						2. DATE OF DEATH MONTH JUNE DAY 2 YEAR 1995			3. TIME OF DEATH 1045 A.M.													
4. SOCIAL SECURITY NUMBER 044-05-8190		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 3, 1918			8. BIRTHPLACE (State or Foreign Country) Connecticut												
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Bethesda						9c. COUNTY OF DEATH Montgomery																
RESIDENCE OF DECEDENT																									
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
10e. STREET AND NUMBER 3641 S. Leisure World Blvd., #2A				10f. ZIP CODE 20906						10g. CITIZEN OF WHAT COUNTRY? United States															
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White															
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) —			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Accountant			16b. KIND OF BUSINESS/INDUSTRY National Automobile Dealers Association																			
17. FATHER'S NAME (First, Middle, Last) William Joseph Granville						18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Smith																			
19a. INFORMANT'S NAME (Type/Print) Richard L. Granville			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5517 Alta Vista Road, Bethesda, Maryland 20814																						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.						20c. LOCATION — City or Town, State Bethesda, Maryland																
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael P. Kutta</i>			22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, Md 20814-3501																						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate interval Between Onset and Death												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →			e. <i>Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF):										1wk												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			b. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF):										2 yrs												
{ c. <i>Diabetes</i> DUE TO (OR AS A CONSEQUENCE OF):			d.										5 yrs.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide							28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)													28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On <i>[Signature]</i> basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Salander, M.D.</i>					29d. LICENSE NUMBER D39064		29e. DATE SIGNED (Month, Day, Year) ► June 2, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) <i>[Signature]</i> James J. Salander, M.D., 11119 Rockville Pike, #204, Rockville, Maryland 20852													31. DATE FILED (Month, Day, Year) JUN 05 1995					32. REGISTRAR'S SIGNATURE <i>Judy Dawson-Robell</i>		DHMH-18 Rev 1/89					

95 19012



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

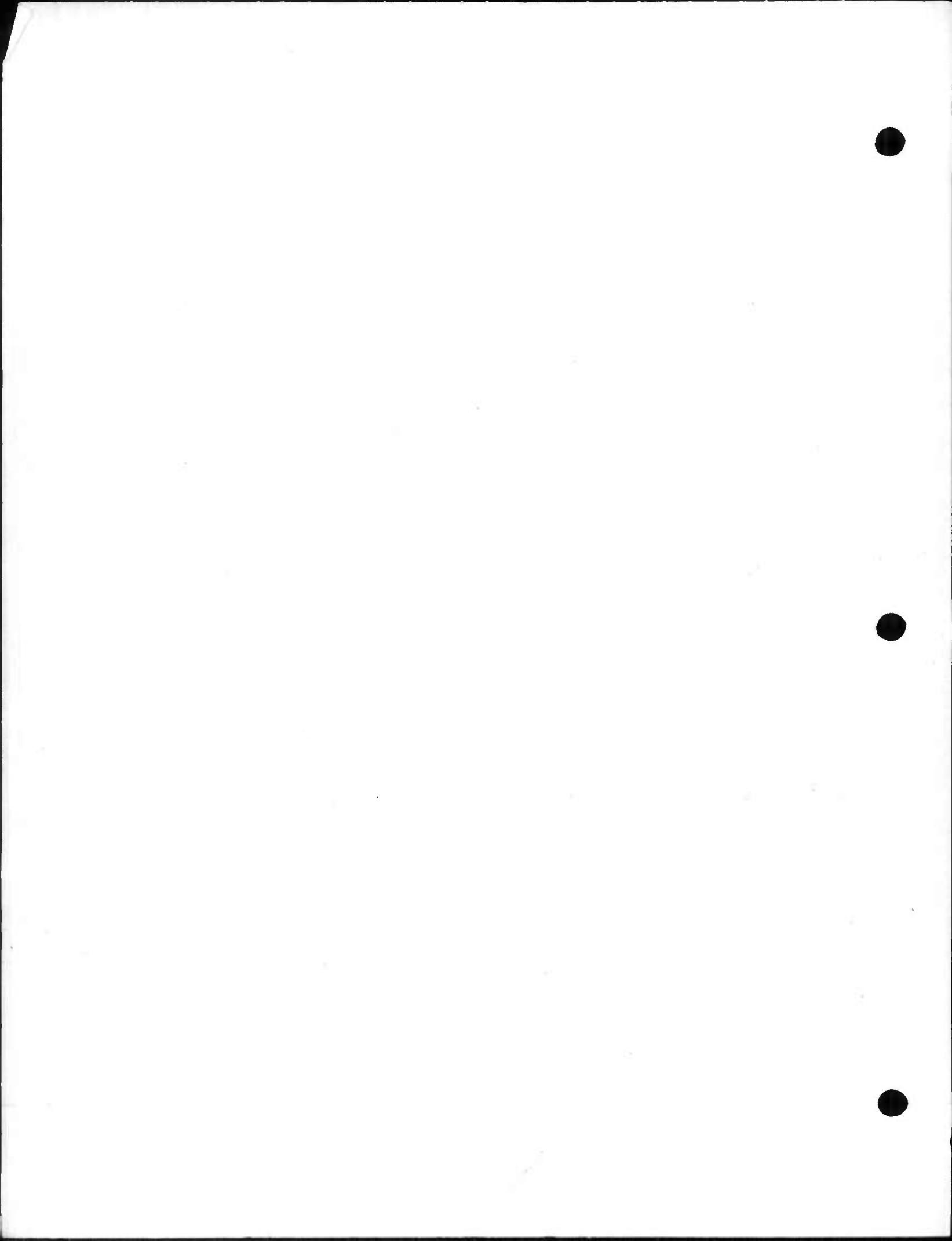
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		Mary M. Griffith						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 4:05 PM			
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
217-28-8416		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	63 YRS.	MONTHS	DAYS	HOURS	MIN.	Aug. 20, 1931		Washington, DC			
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH					
19317 Clubhouse Road, Apt. 202		Gaithersburg						Montgomery					
RESIDENCE OF DECEASED													
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
Maryland	Montgomery		Gaithersburg										
10e. STREET AND NUMBER	10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?						
19317 Clubhouse Road, Apt. 202		20879						United States					
11. MARITAL STATUS	12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY								
Elementary/Secondary (0-12) 12	College (1-4 or 5+)			Account Clerk			Telecommunications Company						
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)								
Ellis Johnson					Austie Blanche Simmons								
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Wanda Lee Russ		927 Grandin Avenue, Rockville, Maryland 20851											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE		20c. LOCATION — City or Town, State							
	Parklawn Memorial Park			June 6, 1995		Rockville, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara McMullan Linchance</i>	22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery avenue, Rockville, Maryland 20850-2805												
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Chronic Renal Failure DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. Calciphylaxis DUE TO (OR AS A CONSEQUENCE OF):													
c. Diabetes DUE TO (OR AS A CONSEQUENCE OF):													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Philip J. Murphy Jr.</i>		29c. LICENSE NUMBER 024398-MARYLAND		29d. DATE SIGNED (Month, Day, Year) ► June 2, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Philip J. Murphy Jr. 15225 Shady Grove Road #302 Rockville, MD 20850</i>													
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE <i>Jean Dawson Marshall</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

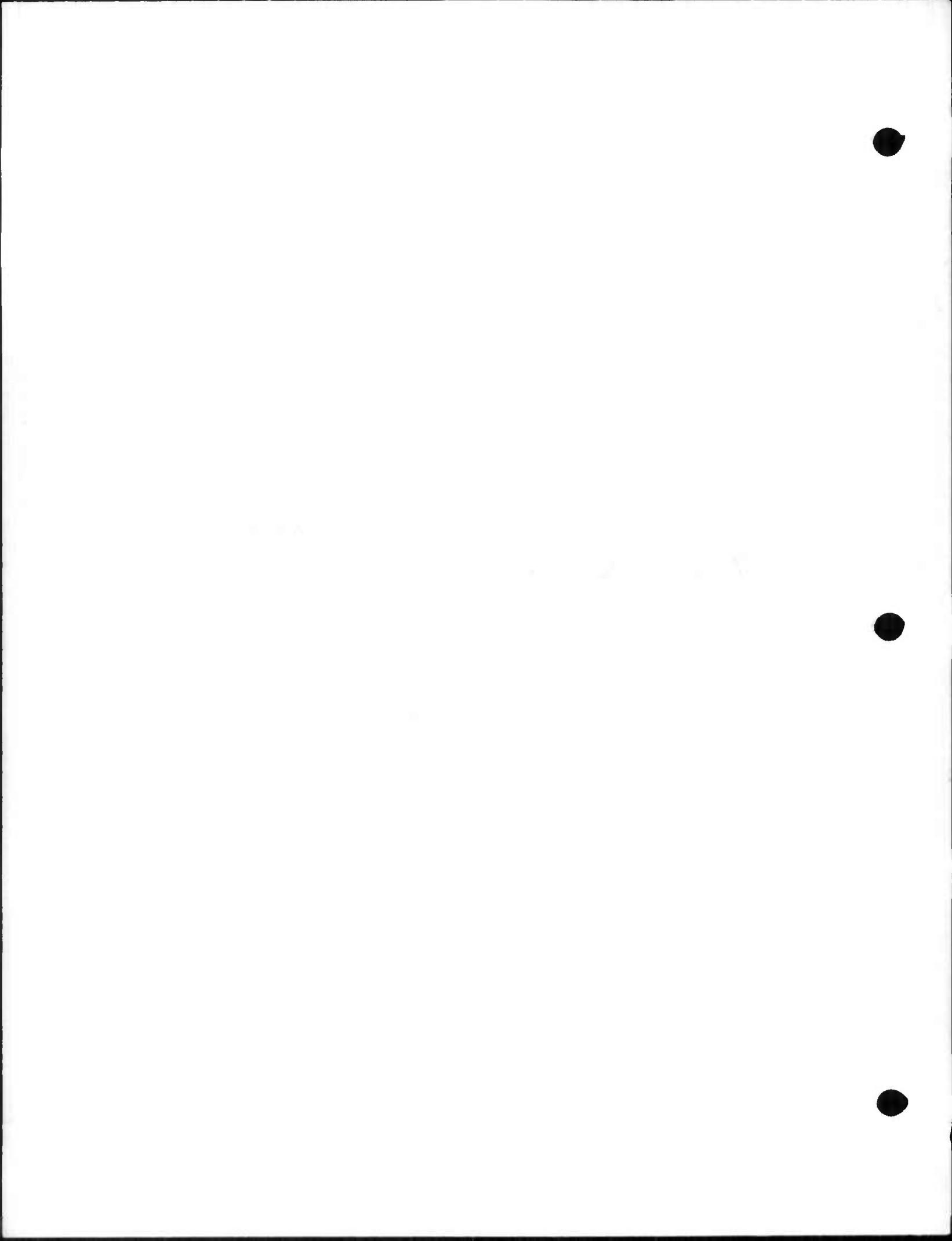
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19014

1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH			3. TIME OF DEATH					
JAMES FRANCIS GOLDSWORTHY												MONTH DAY YEAR			10:14 A M					
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.												
214-28-6564		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		63 YRS.		MONTHS		DAYS												
9a. FACILITY NAME (If not institution, give street and number)												7. DATE OF BIRTH								
Memorial Hospital												(Month, Day, Year)								
9b. CITY, TOWN OR LOCATION OF DEATH												8. BIRTHPLACE (State or Foreign Country)								
Cumberland												MARYLAND								
9c. COUNTY OF DEATH																				
Allegany																				
RESIDENCE OF DECEDENT																				
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?								
MARYLAND		ALLEGANY		CUMBERLAND								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
10e. STREET AND NUMBER												10f. ZIP CODE								
#1 BALTIMORE STREET												21502								
10g. CITIZEN OF WHAT COUNTRY?												U.S.A.								
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?										13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. RACE — American Indian, Black, White, etc. Specify: WHITE					
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1953--1956										1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:								
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)										16b. KIND OF BUSINESS/INDUSTRY								
Elementary/Secondary (0-12)		College (1-4 or 5+) 5+										ASSOC. PROFESSOR			ART EDUCATION UNIVERSITY					
17. FATHER'S NAME (First, Middle, Last)												18. MOTHER'S NAME (First, Middle, Maiden Surname)								
PAUL R. GOLDSWORTHY												HELEN T. PUGH								
19a. INFORMANT'S NAME (Type/Print)												19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
JOAN MARTIN												805 MT. ROYAL AVE.-CUMBERLAND, MD 21502								
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)										20c. LOCATION — City or Town, State								
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		ST. MARY'S CEMETERY 6/6/95										CUMBERLAND, MD								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE												22. NAME AND ADDRESS OF FACILITY								
Wendy G. Upchurch												GEORGE-UPCHURCH FUNERAL HOME, P.A. 202 GREENE ST., CUMBERLAND, MD 21502								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												75 minutes								
a. Suicide DUE TO (OR AS A CONSEQUENCE OF):																				
b. Depression DUE TO (OR AS A CONSEQUENCE OF):												4 years								
c. _____ DUE TO (OR AS A CONSEQUENCE OF):																				
d. _____ DUE TO (OR AS A CONSEQUENCE OF):																				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Far Advanced Cancer of Prostate												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																				
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)																		
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																		
27. MANNER OF DEATH												28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURED	
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide												M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)																	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)												1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29b. SIGNATURE AND TITLE OF CERTIFIER Donald Manger MD DME												29c. LICENSE NUMBER D0923			29d. DATE SIGNED (Month, Day, Year)					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															June 3, 1995					
Dr. Donald Manger Rt 2 Hazen Road Cumberland, MD 21502																				
31. DATE FILED (Month, Day, Year)												32. REGISTRAR'S SIGNATURE Julia Dawson-Randall								
JUN 06 1995																				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

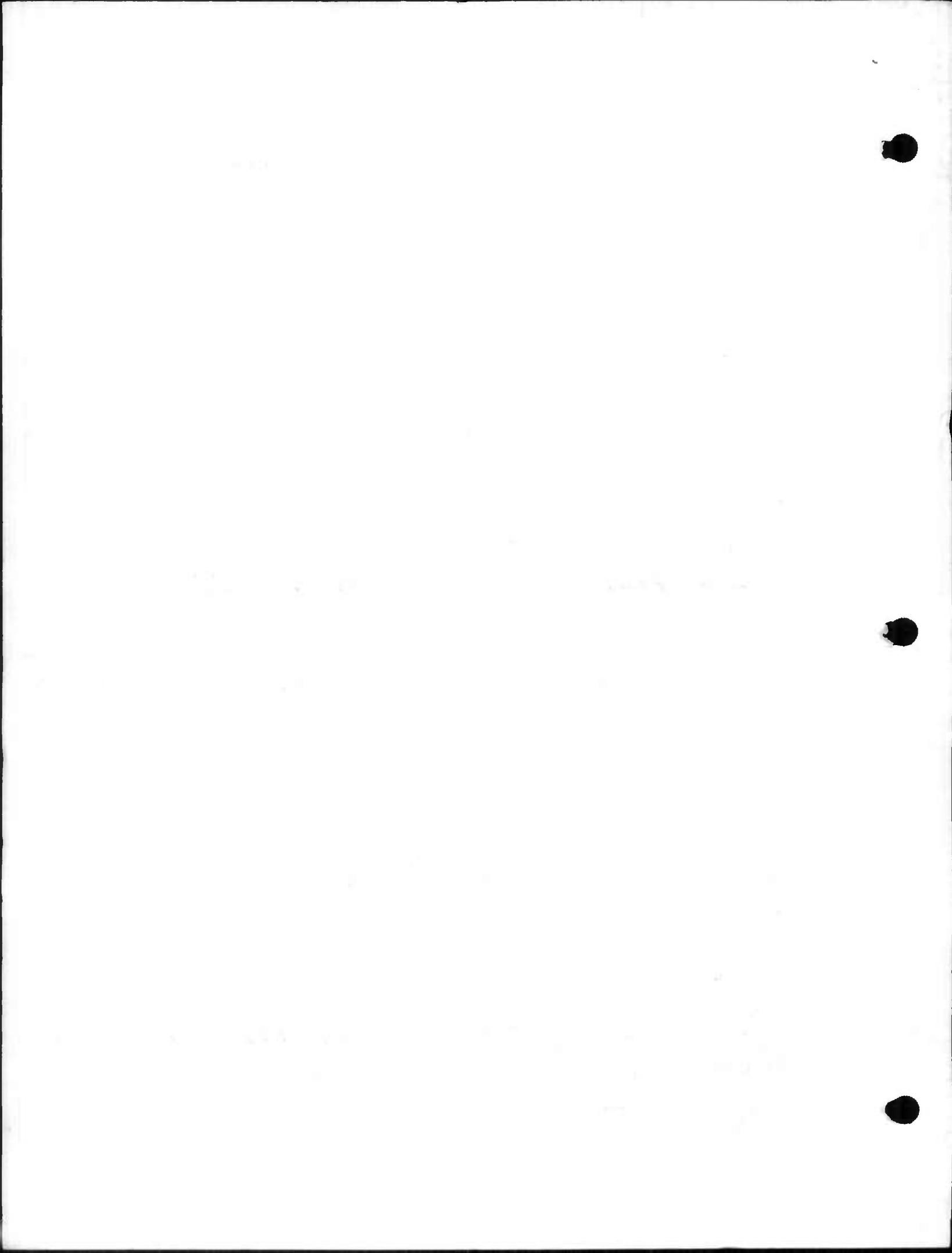
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH <i>Jane 11</i>	3. TIME OF DEATH YEAR <i>95 1617 M</i>				
Arnold Emile Greene										7. DATE OF BIRTH (Month, Day, Year) <i>Sept 12, 1923</i>	8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>				
4. SOCIAL SECURITY NUMBER <i>213-16-7559</i>										5. SEX <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>71 YRS.</i>	IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/>	MIN. <input type="checkbox"/>	
9e. FACILITY NAME (If not institution, give street and number) <i>600 Academy Street</i>										9b. CITY, TOWN OR LOCATION OF DEATH <i>Cambridge</i>			9c. COUNTY OF DEATH <i>Dorchester</i>		
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Dorchester</i>		10c. CITY, TOWN OR LOCATION <i>Cambridge</i>					10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER <i>600 Academy Street</i>					10f. ZIP CODE <i>21613</i>					10g. CITIZEN OF WHAT COUNTRY? <i>US</i>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i>			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i></i>			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>9</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) <i>Truck Driver</i>			16b. KIHD OF BUSINESS/INDUSTRY <i>Seafood</i>										
17. FATHER'S NAME (First, Middle, Last) <i>William Thomas Greene</i>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>May Ida Schultz</i>										
19a. INFORMANT'S NAME (Type/Print) <i>A. Frances Wright</i>					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3662 Karen Circle Linkwood, Maryland 21835</i>										
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) <i>—</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Md. Veterans Cemetery</i>			DATE <i>6/14</i>		20c. LOCATION — City or Town, State <i>Hurlock, Maryland</i>								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John J. Donahue</i>					22. NAME AND ADDRESS OF FACILITY <i>Thomas Funeral Home, P.A. 700 Locust St. Cambridge, Maryland 21613</i>										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>MYOCARDIAL INFARCTION</i> DUE TO (OR AS A CONSEQUENCE OF):										<i>30 MINUTES</i>					
b. <i>ALCOHOLIC CARDIOMYOPATHY</i> DUE TO (OR AS A CONSEQUENCE OF):										<i>YEARS</i>					
c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):															
d. <i></i>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA			OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) <i></i>										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year) <i></i>			28b. TIME OF INJURY M <input type="checkbox"/>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
8 <input type="checkbox"/> Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i></i>			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i></i>										
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29g. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Donahue MD</i>					29c. LICENSE NUMBER <i>D10947</i>					29d. DATE SIGNED (Month, Day, Year) <i>► 11 June 95</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dorchester General Hospital, Cambridge, MD</i>															
31. DATE FILED (Month, Day, Year) <i>JUN 13 1995</i>		32. REGISTRAR'S SIGNATURE <i>Julia A. Walker-Randall</i>													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

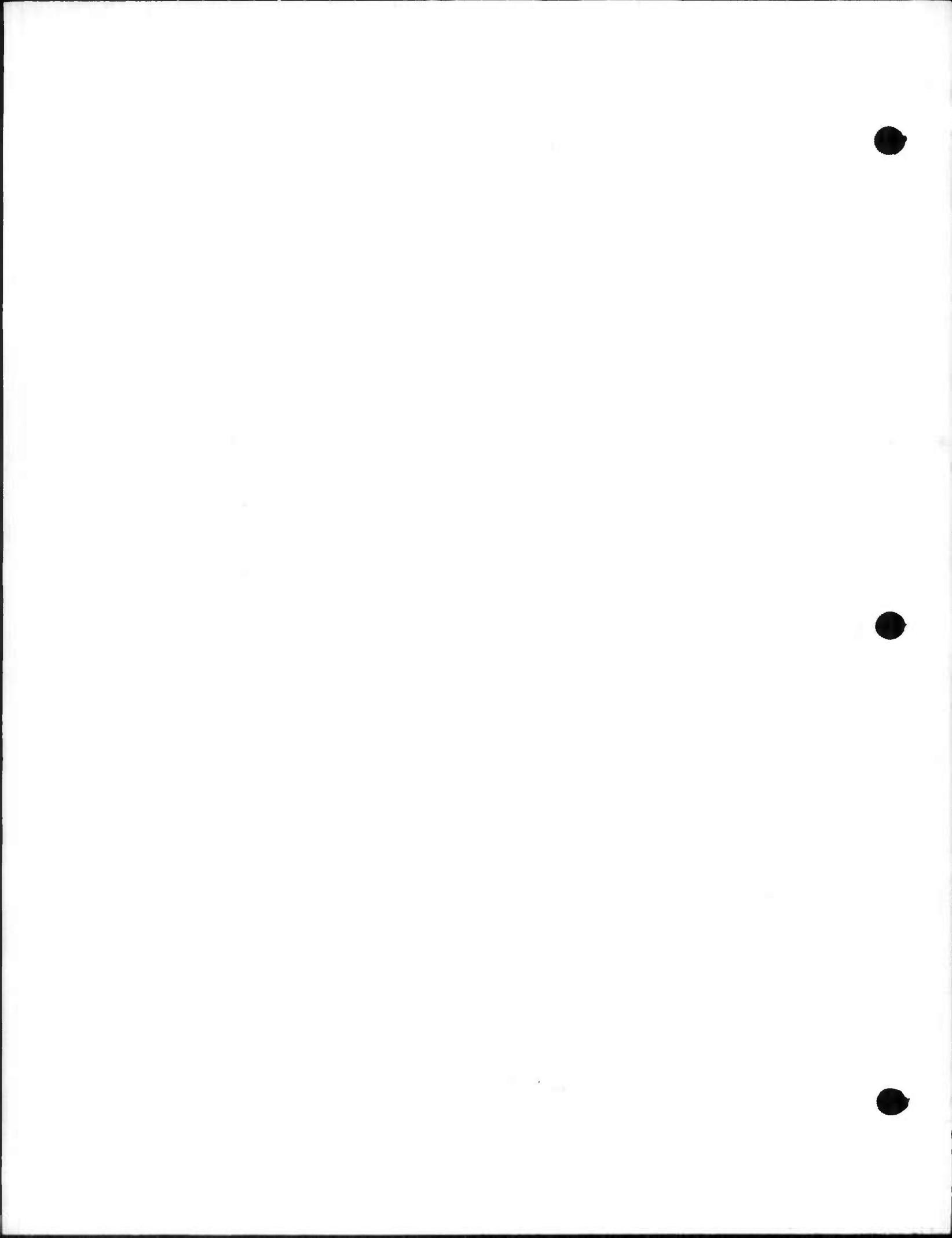
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH MONTH DAY YEAR
Karl F. Gerhard										May 22 1995	6:40 PM
4. SOCIAL SECURITY NUMBER 161 14 1354		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 17, 1915		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 11312 Bird River Grove Rd.										9b. CITY, TOWN OR LOCATION OF DEATH White Marsh	
9c. COUNTY OF DEATH Baltimore											
RESIDENCE OF DECEASED											
10a. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Crofton								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1508 Eton Way										10f. ZIP CODE 21114	10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Physicist				16b. KIND OF BUSINESS/INDUSTRY U.S. Government					
17. FATHER'S NAME (First, Middle, Last) Charles Frederick Gerhard										18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude E. Sullivan	
19a. INFORMANT'S NAME (Type/Print) Marie Gerhard Parr					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11312 Bird River Grove Road White Marsh Md. 21162						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory					DATE 5/26/95	20c. LOCATION — City or Town, State Alexandria Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>► Robert E. Evans, Pres</i>					22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 3 year	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>METASTATIC CARCINOMA OF LIVER</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined					28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
					28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steven Gore MD</i>										29c. LICENSE NUMBER P35US1	29d. DATE SIGNED (Month, Day, Year) ► 5-23-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN GORE JOHNS HOPKINS ONCOLOGY CENTER, Baltimore MD											
31. DATE FILED (Month, Day, Year) JUN 05 1995					32. REGISTRAR'S SIGNATURE <i>Jill Davelar Kortell</i>						



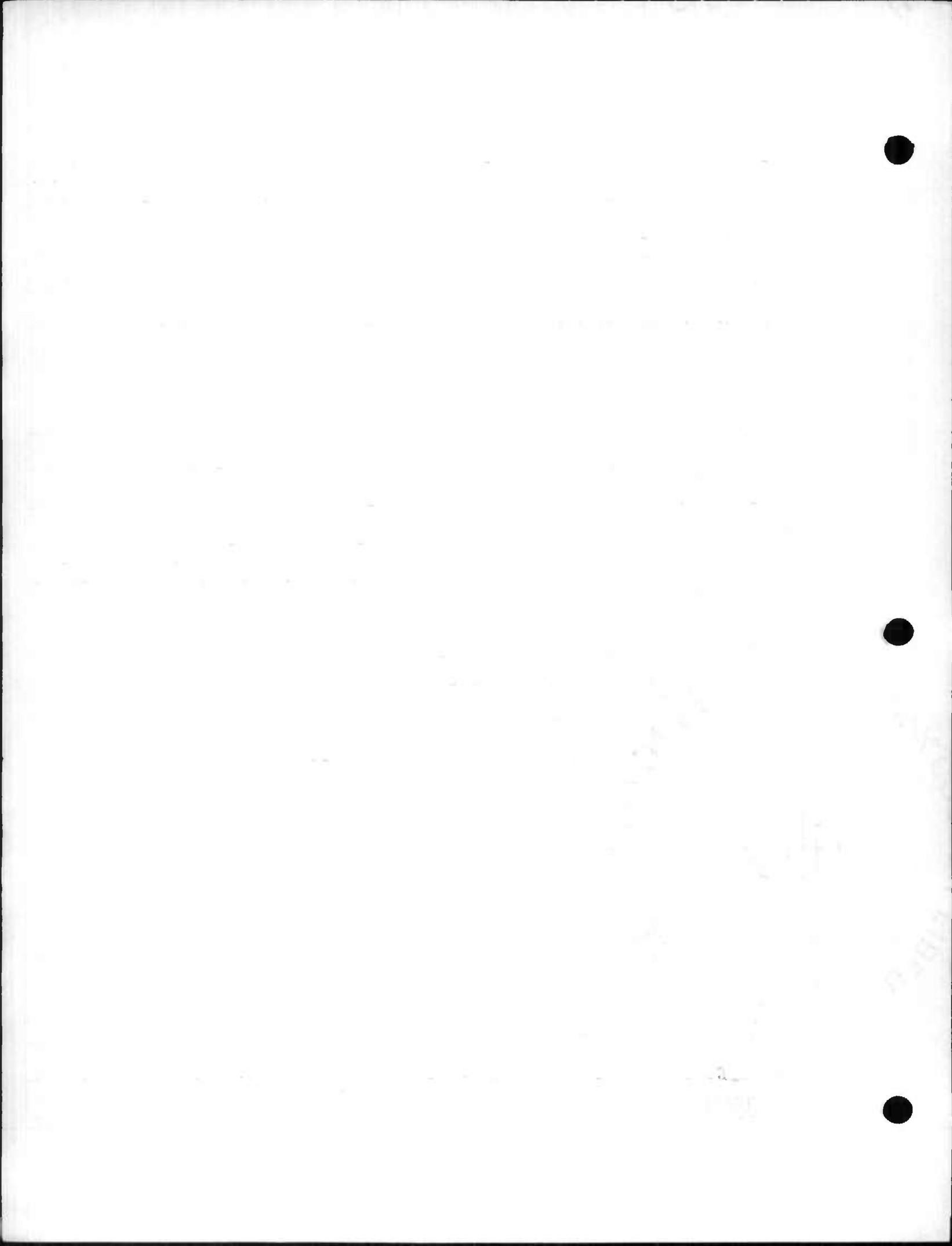
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.		
						2. DATE OF DEATH MONTH MAY	DAY 30	YEAR 1995	3. TIME OF DEATH 7:54A	
1. DECEDENT'S NAME (First, Middle, Last) LEONARD GILCHRIST						7. DATE OF BIRTH (Month, Day, Year) JAN. 18, 1920			8. BIRTHPLACE (State or Foreign Country) S.C. PLUM BRANCH	
4. SOCIAL SECURITY NUMBER 251 16 5848		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0		MIN. 0		
9a. FACILITY NAME (If not institution, give street and number) 17521 SIR GALAHAD WAY						9b. CITY, TOWN OR LOCATION OF DEATH ASHTON			9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE D.C.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION WASHINGTON						10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO
10e. STREET AND NUMBER 116 17TH. STREET, N.E.						10f. ZIP CODE 20002			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN			16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CONSTRUCTION WORKER			16b. KIND OF BUSINESS/INDUSTRY PRIVATE				
17. FATHER'S NAME (First, Middle, Last) JAMES GILCHRIST						18. MOTHER'S NAME (First, Middle, Maiden Surname) GEORGIA HOLMES				
19a. INFORMANT'S NAME (Type/Print) ELOISE P. WIDGEON						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17521 SIR GALAHAD WAY, ASHTON, MD 20861				
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 6/2			DATE		20c. LOCATION — City or Town, State LANDOVER, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dudley						22. NAME AND ADDRESS OF FACILITY E.M. DUDLEY FUNERAL HOME, 3200 R.I.AVE., MT. RAINIER, MD. 20712				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death
<p>a. EMACIATION & MALNUTRITION DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. CANCER OF THE LUNGS DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. METASTASE DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. HYPERTENSION & DIABETES MELLITUS</p>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
27. MANNER OF DEATH 1 □ Natural 5 □ Pending Investigation 2 □ Accident 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? 1 □ YES 2 □ NO		28d. DESCRIBE HOW INJURY OCCURRED		
6 □ Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Clarence Coleman						29c. LICENSE NUMBER DC 2774		29d. DATE SIGNED (Month, Day, Year) 5/30/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. CLARENCE COLEMAN, 4402 N. HELEN BURROUGHS AVE., NE., WASH., DC.						32. REGISTRAR'S SIGNATURE John Davidson Harrell				
31. DATE FILED (Month, Day, Year) JUN 02 1995										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

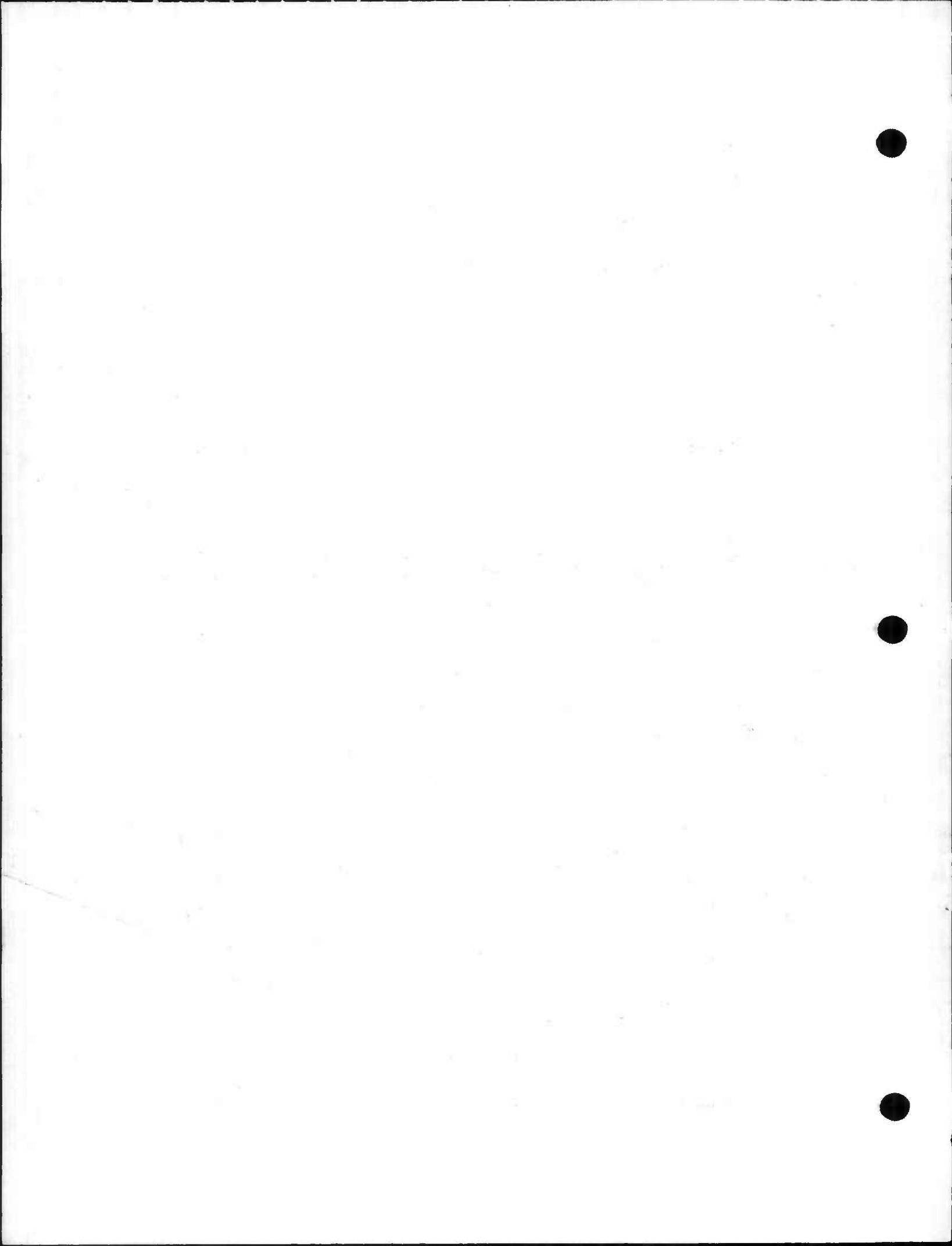
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19018

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEASED'S NAME (First, Middle, Last)		Donald Eugene Gourley					2. DATE OF DEATH		3. TIME OF DEATH				
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTH DAY YEAR		1:56 P.M.			
161-18-4763		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	74 YRS.	MONTHS		DAYS		HOURS		MIN.			
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH					7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)				
Doctor's Community Hospital		Lanham					Feb. 24, 1921		Pennsylvania				
9c. COUNTY OF DEATH Prince George's													
RESIDENCE OF DECEASED													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
Maryland		Prince George's		Berwyn Heights					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER							10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?				
5803 Berwyn Road							20740		U.S.A.				
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES					13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:						
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced							14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Salesman					Private Industry						
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)											
Frank Gourley		Jesse Garvey											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Vada L. Gourley		5803 Berwyn Road, Berwyn Heights, Maryland 20740											
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)					DATE		20c. LOCATION — City or Town, State				
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metropolitan Crematory					06/07/95		Alexandria, Virginia				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY											
Charles F. Bell		Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
b. DUE TO (OR AS A CONSEQUENCE OF): Acute Myocardial Infarction >1 yr													
c. DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery disease >1 yr													
d. DUE TO (OR AS A CONSEQUENCE OF): Hypertension													
Approximate Interval Between Onset and Death 1/2 yr >1 yr >1 yr													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Osteoarthritis													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER							29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)				
Robert Ruderman		6510 Kenilworth Ave. Riverdale, Md. 20737					DD9874		► 6-5-95				
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE											
JUN 08 1995		John David Randall											



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

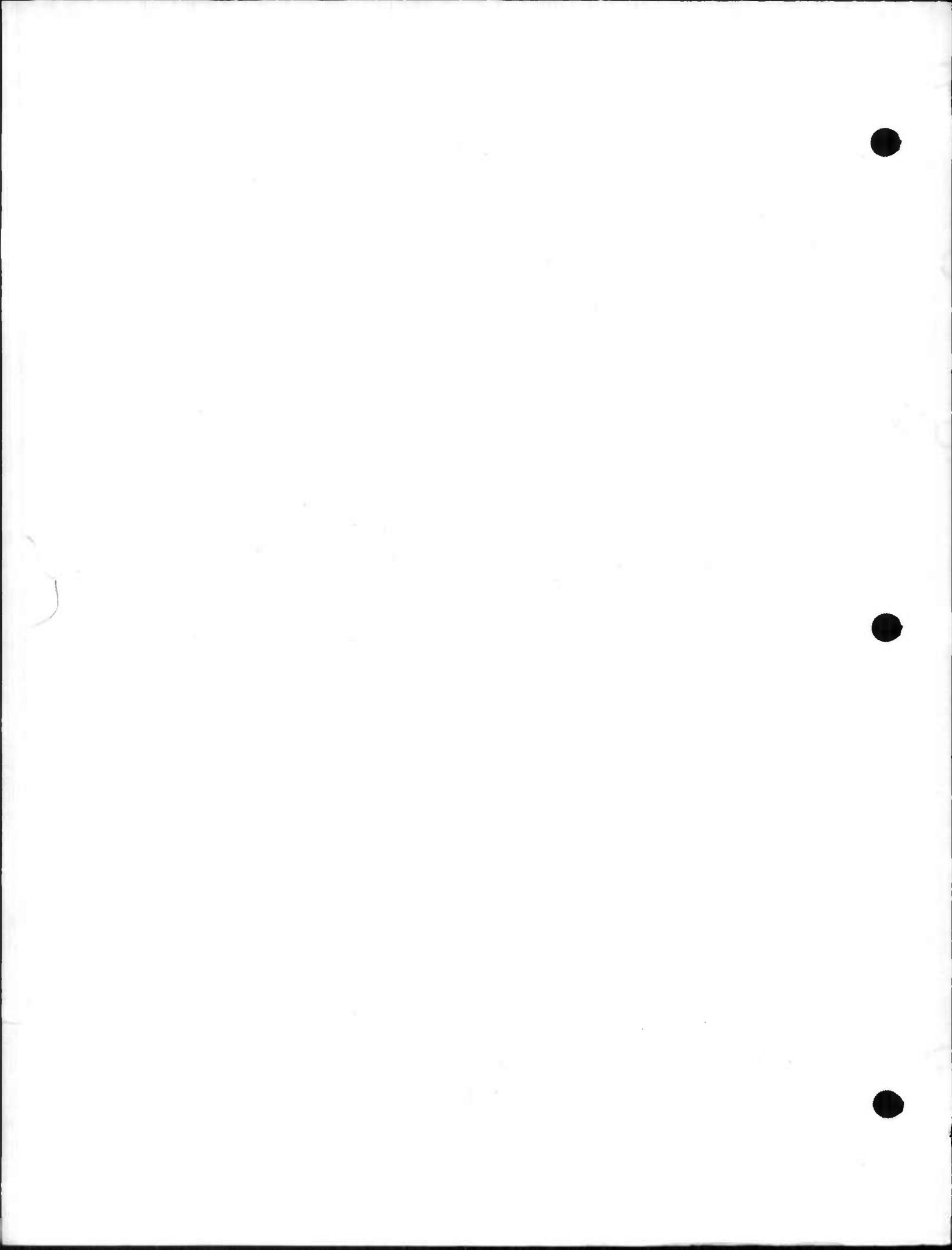
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - FOR STATE REGISTRAR		JAMES P. Grant								2. DATE OF DEATH MONTH DAY YEAR JUNE 1 1995 748 A M					
4. SOCIAL SECURITY NUMBER 213 07 1731		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		3. TIME OF DEATH 8. BIRTHPLACE (State or Foreign Country) South Carolina					
8a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park								9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie		10d. INSIDE CITY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10g. CITIZEN OF WHAT COUNTRY? United States							
10e. STREET AND NUMBER 15508 Norwegian Court		10f. ZIP CODE 20716								14. RACE — American Indian, Black, White, etc. Specify: White					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tool and Die Maker		16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
17. FATHER'S NAME (First, Middle, Last) Charles Asbury Grant		18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Mae Tally													
19a. INFORMANT'S NAME (Type/Print) Carolyn S. Bock		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15508 Norwegian Court Bowie Maryland 20716													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gardens								20c. LOCATION — City or Town, State Timonium Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres		22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ANTEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death many years															
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Paula A. De Korte MD		29c. LICENSE NUMBER DO 1852		29d. DATE SIGNED (Month, Day, Year) ► JUNE 1 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paula A. De Korte MD 4103 Queensbury Rd Hyattsville MD 20781															
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE Julie Dawson-Randall													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

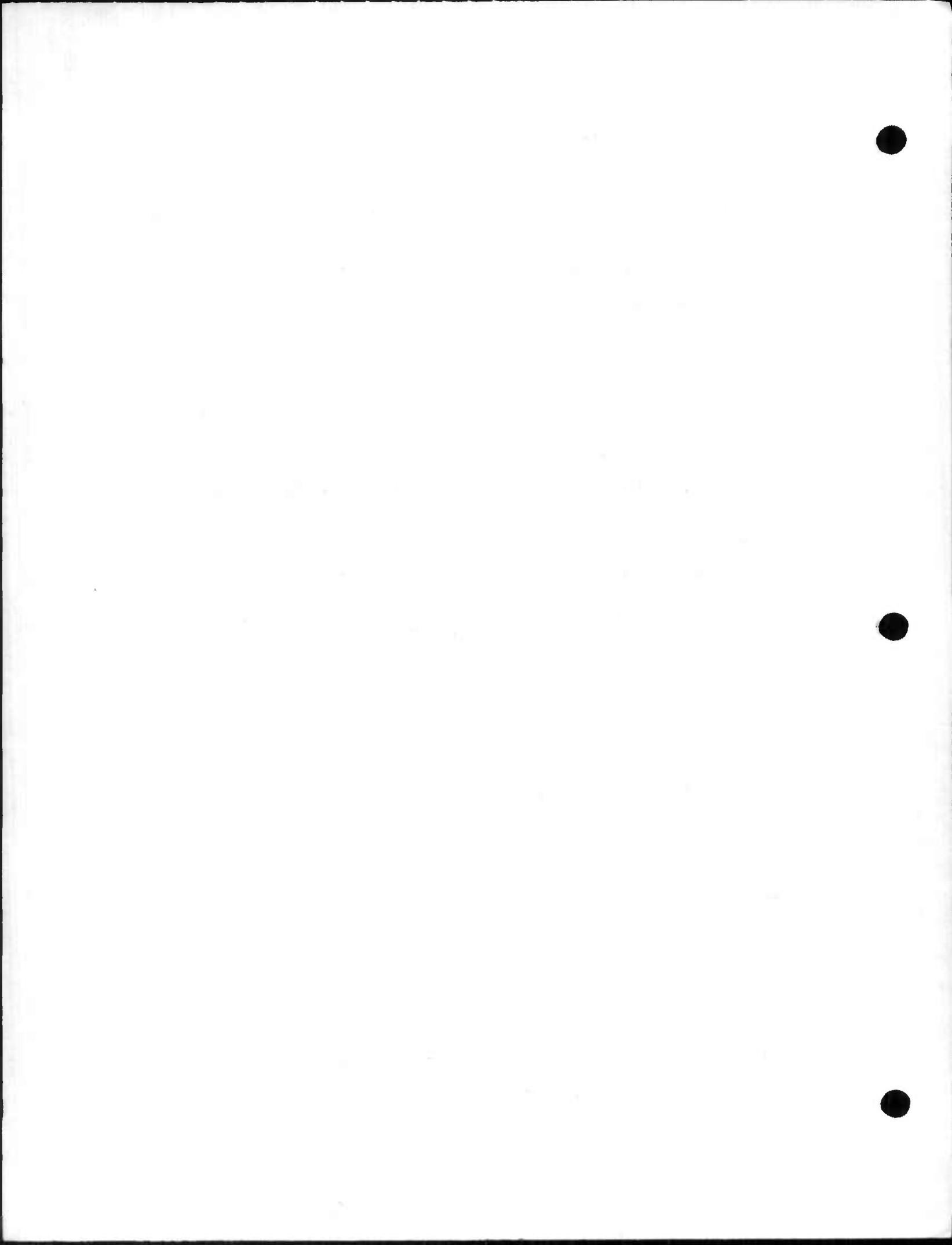
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19020

1. DECEASED'S NAME (First, Middle, Last)		Richard W. Gilbert				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 30, 1958	8. BIRTHPLACE (State or Foreign Country) Washington, DC
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville				9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Fort Washington				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 6100 Saint Ignatius Drive		10f. ZIP CODE 20744				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Registered Nurse		16b. KIND OF BUSINESS/INDUSTRY Medical			
17. FATHER'S NAME (First, Middle, Last) John T. Gilbert		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lorraine M. Weiss					
19a. INFORMANT'S NAME (Type/Print) Lorraine M. Killion		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6916 Trowbridge Pl. Ft. Washington, Md. 20744					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Metropolitan Crematory		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		DATE 6-6-95	20c. LOCATION — City or Town, State Alexandria, Virginia		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>acquired immune deficiency syndrome</i></p> <p>b. <i>due to (or as a consequence of):</i></p> <p>c. <i>due to (or as a consequence of):</i></p> <p>d. <i>due to (or as a consequence of):</i></p>							
<p>24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>							
<p>25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></p> <p>26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
<p>29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. SIGNATURE AND TITLE OF CERTIFIER </p> <p>29c. LICENSE NUMBER DO 1499</p> <p>29d. DATE OF EXAMINATION 6/6/95</p>							
<p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)</p> <p>Lewis Dennis, M.D. 6201 Greenbelt Rd. U-1 College Park, Md. 20740</p> <p>31. DATE FILED (Month, Day, Year) JUN 08 1995</p> <p>32. REGISTRAR'S SIGNATURE </p>							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

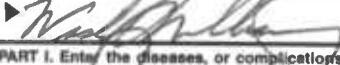
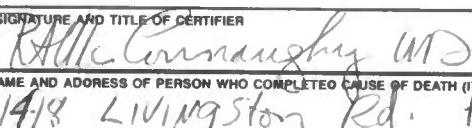
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

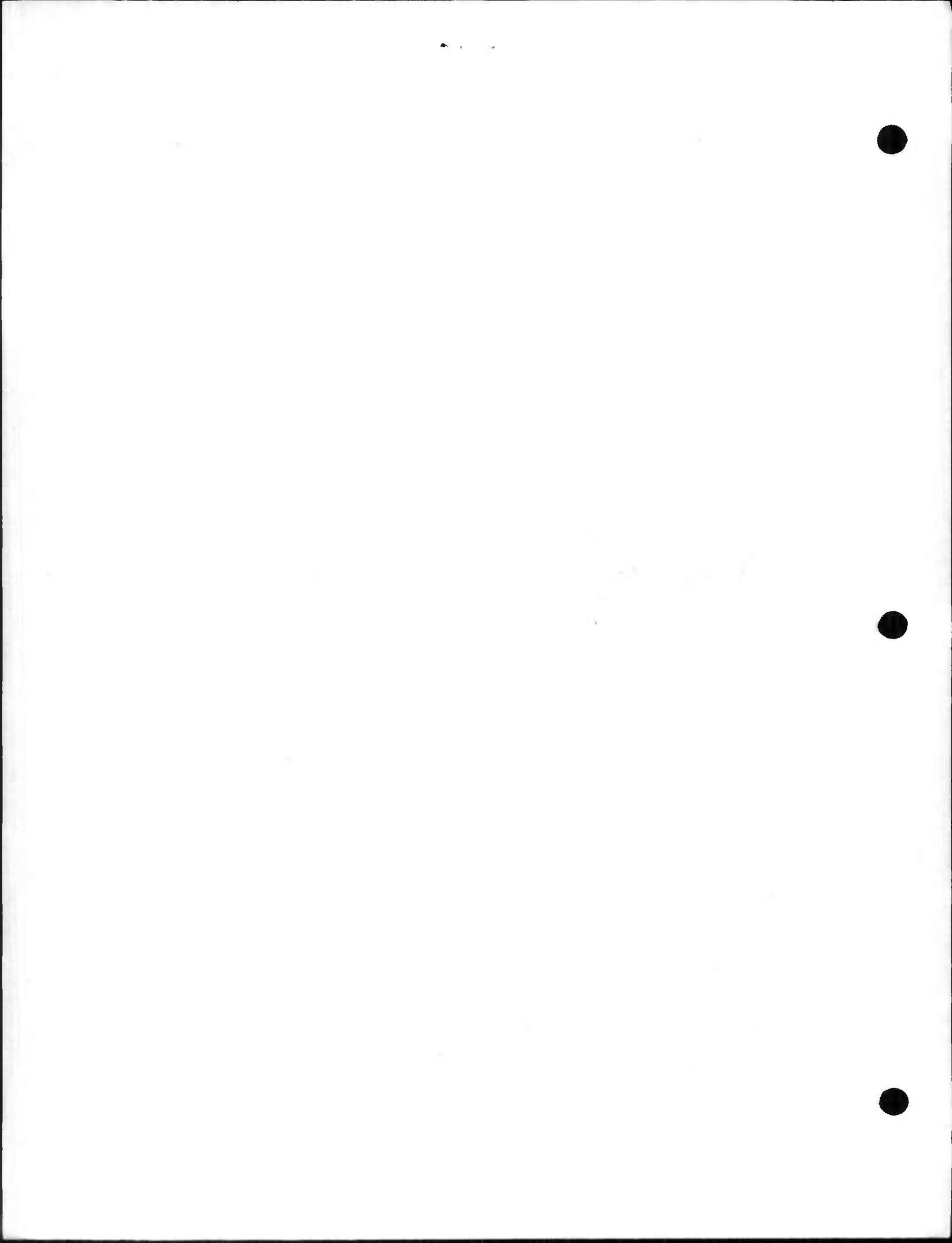
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
JAMES GORE											JUNE 8 1995	9:15 P.M.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS.							
213-12-1204		XX M 2 <input type="checkbox"/> F	79 YRS.	MONTHS	DAYS	HOURS	MIN.					
9a. FACILITY NAME (If not institution, give street and number) Fort Washington Medical Center											7. DATE OF BIRTH (Month, Day, Year) September 20, 1915	8. BIRTHPLACE (State or Foreign Country) South Carolina
9b. CITY, TOWN OR LOCATION OF DEATH Fort Washington											9c. COUNTY OF DEATH Prince George	
RESIDENCE OF DECEDENT												
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland	Charles	Indian Head										
10e. STREET AND NUMBER 14 Potomac Ave.				10f. ZIP CODE 20640					10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1934-1938			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Agent			16b. KIND OF BUSINESS/INDUSTRY Life Insurance							
17. FATHER'S NAME (First, Middle, Last) John Robert Gore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nancy Tildon Carter								
19a. INFORMANT'S NAME (Type/Print) Berthalene Gore				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) June 12, 1995 Date Trinity Memorial Gardens Location — City or Town, State Waldorf, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. Arteriosclerotic Cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF):												
b. Arteriosclerotic Heart Disease DUE TO (OR AS A CONSEQUENCE OF):												
c. Adrenal Insufficiency DUE TO (OR AS A CONSEQUENCE OF):												
d. Renal Insufficiency												
Approximate Interval Between Onset and Death												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Rheumatoid arthritis Pseudogout												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER DO 7287				29d. DATE SIGNED (Month, Day, Year) ► 6-9-95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 11418 Livingston Rd. Fort Washington, Md. 20744												
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE 										



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

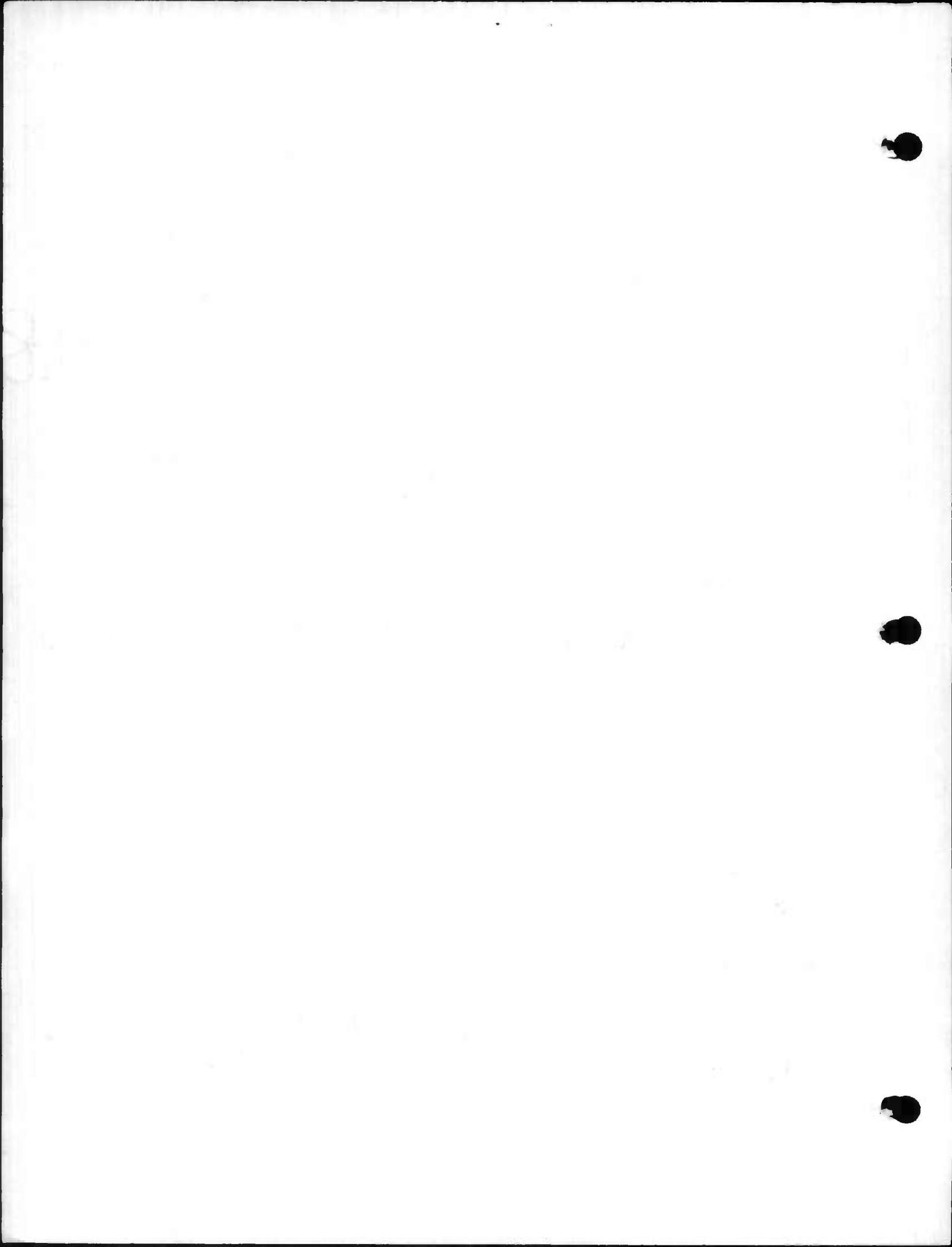
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
JOHN PHILLIP GREENBANK						June 11 1995	9:40 P M		
4. SOCIAL SECURITY NUMBER 217-52-1748		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 40 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jul 9, 1954	8. BIRTHPLACE (State or Foreign Country) Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number) 7150 Brooks Road			9b. CITY, TOWN OR LOCATION OF DEATH Highland			9c. COUNTY OF DEATH Howard			
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Highland			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 7150 Brooks Road			10f. ZIP CODE 20777			10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2		16b. KIND OF BUSINESS/INDUSTRY Supervisor/Pressman			Check Printing		
17. FATHER'S NAME (First, Middle, Last) Robert K. Greenbank				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anne Schillinger					
19a. INFORMANT'S NAME (Type/Print) Kathleen Greenbank			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7150 Brooks Road Highland, Maryland 20777						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. John's Cemetery			20c. LOCATION — City or Town, State 6-15 Ellicott City, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Shem A. Collins</i>			22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc. 4112 Old Columbia Pike Ellicott City 21043						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Adercarcinoma of Unknown Primary</i> DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death One year	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kenneth M. W. MD 18111 Prince Philip Dr. Olney MD 20832</i>		29c. LICENSE NUMBER D33886							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)									
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>Julia Shuler-Randall</i>							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

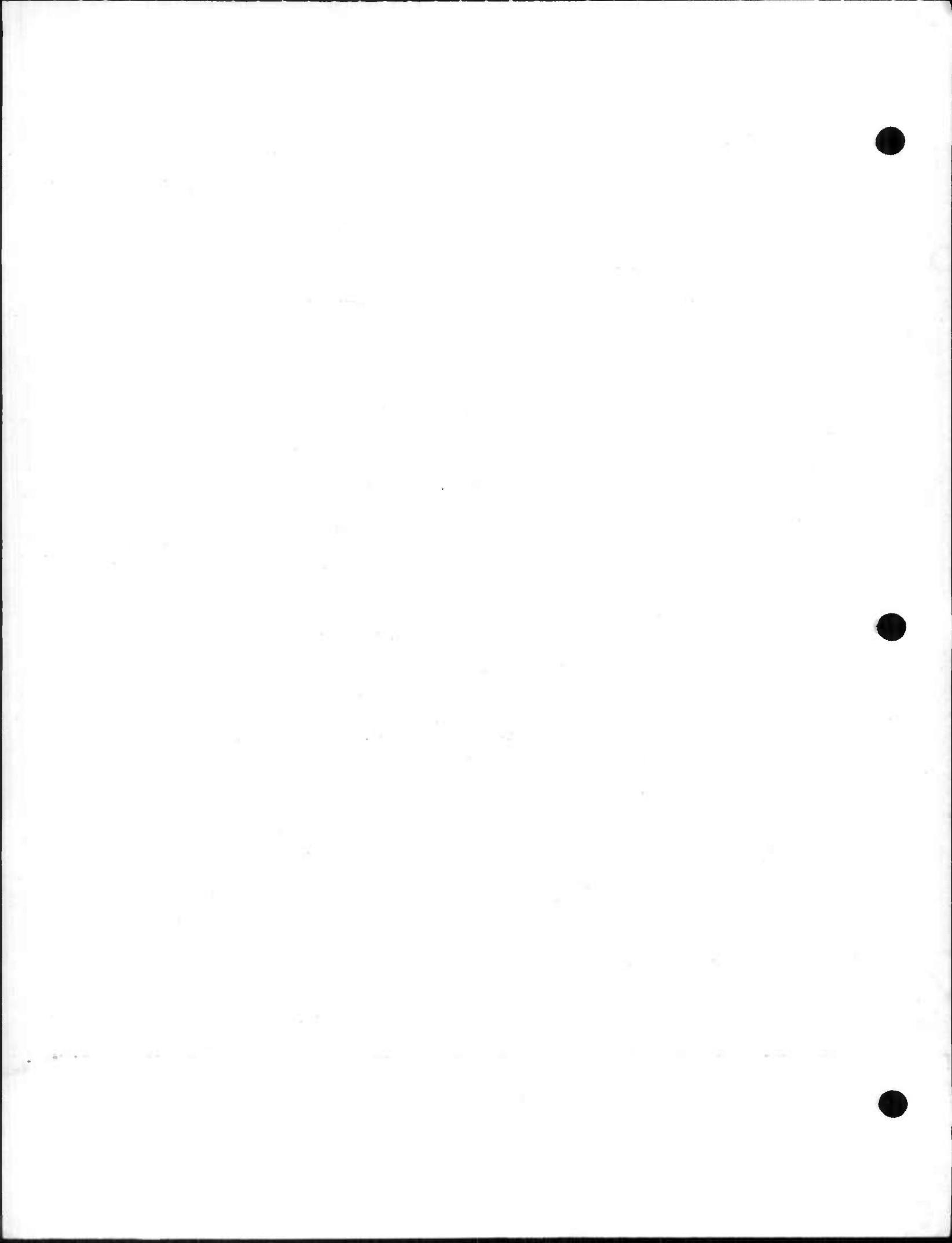
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR			
Marvin Leroy Howard										June 05 1995 0325 AM			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year)			
214-32-7644		<input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		58 YRS.						Nov. 11, 1936			
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH			
Shady Grove Adventist Hospital										Rockville			
9c. COUNTY OF DEATH										Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
Maryland		Montgomery		Rockville								<input checked="" type="checkbox"/>	
10e. STREET AND NUMBER										10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
1221 Clagett Drive										20851		United States	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1955-1961											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 12		College (1-4 or 5+) — Plumber								Plumbing			
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Francis William Howard										Ethel Emma Mills			
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Delores B. Howard										1221 Clagett Drive, Rockville, Maryland 20851			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)								20c. LOCATION — City or Town, State			
		June 8, 1995 Parklawn Memorial Park								Rockville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Kutta</i>										22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805			
M00348													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <i>subarachnoid hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF):										18 hrs			
b. <i>IVON Traumatic subdural hematoma</i> DUE TO (OR AS A CONSEQUENCE OF):										2 wks			
c. <i>probable intracranial aneurysm</i> DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Melissa Neiman</i>		29c. LICENSE NUMBER D 42368		29d. DATE SIGNED (Month, Day, Year) ► June 5, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Melissa Neiman MD</i>		JUN 08 1995 Fernwood Rd #601 Bethesda MD											
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE <i>Julin Shulman-Randall</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

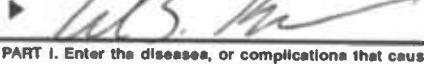
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

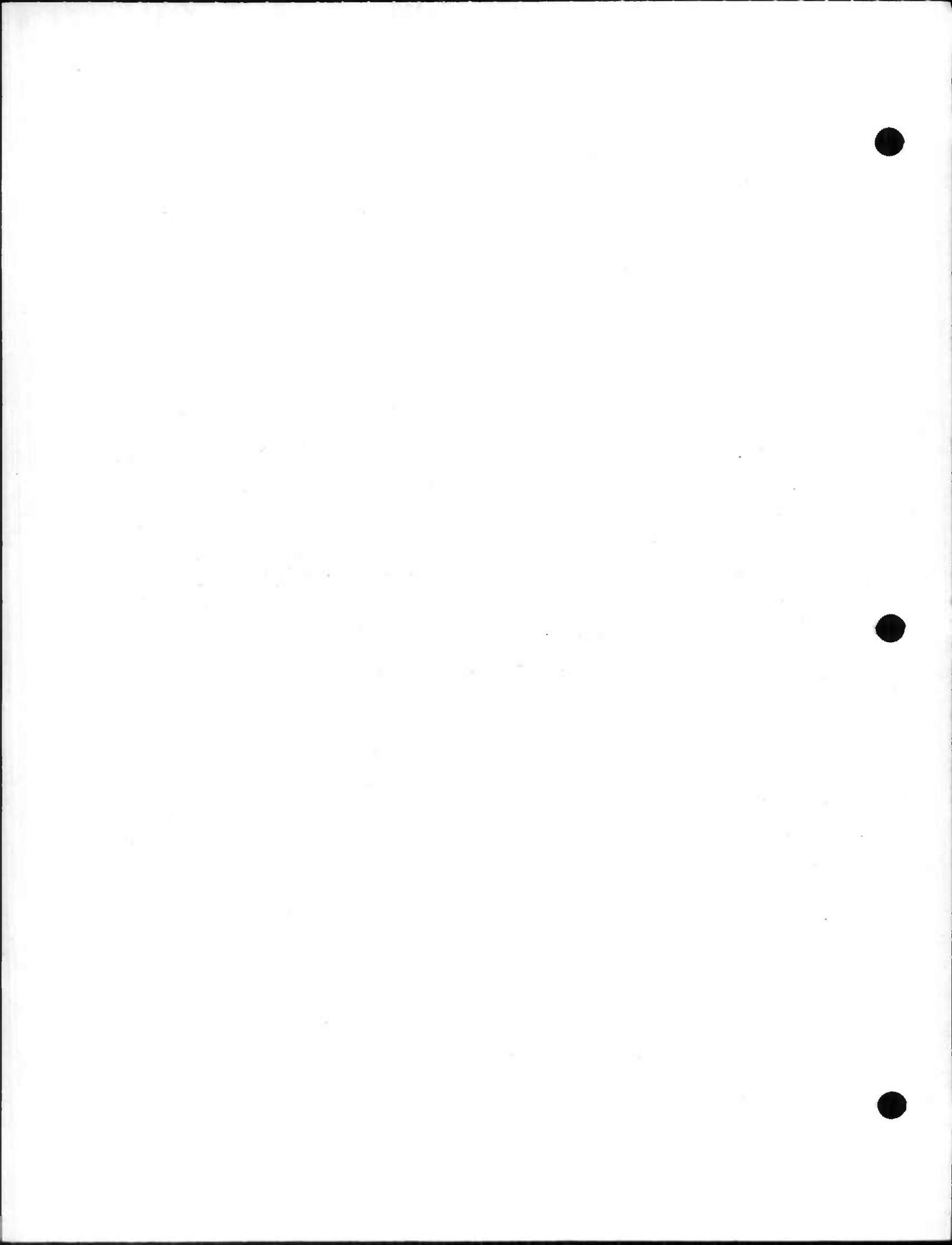
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH HOUR MINUTE
Sung Sook Kim Hahn											June 5, 1995	4:10 A.M.
4. SOCIAL SECURITY NUMBER 212-82-7585		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Apr. 27, 1908		8. BIRTHPLACE (State or Foreign Country) Korea				
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Bethesda			9c. COUNTY OF DEATH Montgomery						
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 9713 Sotweed Drive				10f. ZIP CODE 20854			10g. CITIZEN OF WHAT COUNTRY? Korea					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Korean				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Woong Shik Kim				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jung Sun Kim								
19a. INFORMANT'S NAME (Type/Print) Sung Hahn				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1232 Gilman Court, Herndon, Virginia 22070								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			DATE 6/9			20c. LOCATION — City or Town, State Silver Spring, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Hypertension Coro</i>												
b. <i>Hypertension Coro</i> DUE TO (OR AS A CONSEQUENCE OF): <i> </i>												
c. <i> </i> DUE TO (OR AS A CONSEQUENCE OF): <i> </i>												
d. <i> </i>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson Disease</i>												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) M 28b. TIME OF INJURY 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED										
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28d. DESCRIBE HOW INJURY OCCURED			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sung Sook Kim</i>		29c. LICENSE NUMBER 020516			29d. DATE SIGNED (Month, Day, Year) <i>6/15/95</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Wm Al Bergman Jr Bethesda MD 20814</i>												
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE <i>Jeanine Shuckor-Randall</i>										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

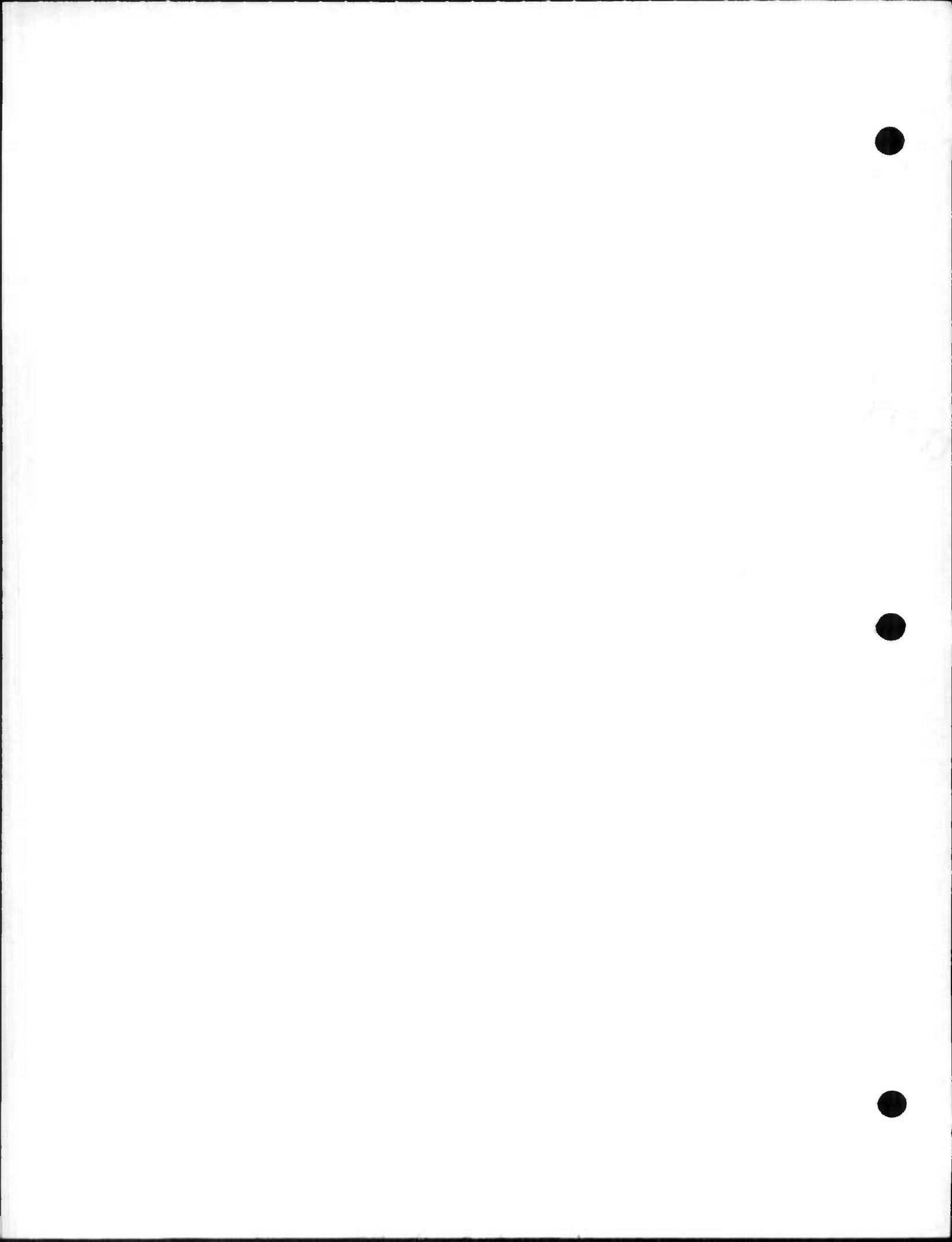
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 95 19025	
1. DECEDENT'S NAME (First, Middle, Last) Melvin W. Harding		melvin woodrow Harding				2. DATE OF DEATH MONTH DAY YEAR June 6, 1995		3. TIME OF DEATH 3:02AM M	
4. SOCIAL SECURITY NUMBER 220-12-3082		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 9, 1924		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Olney, Md. 20832				9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4600 Harlan Street		10f. ZIP CODE 20853				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor			16b. KIND OF BUSINESS/INDUSTRY Animal Care/ N.I.H.				
17. FATHER'S NAME (First, Middle, Last) Albert Vernon Harding		18. MOTHER'S NAME (First, Middle, Maiden Surname) Debbie Ruth Harding							
19a. INFORMANT'S NAME (Type/Print) Debbie Ruth Kidwell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9804 Dr. Perry Road, Ijamsville, Maryland 21754							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Oak Cemetery			DATE 6/9		20c. LOCATION — City or Town, State Gaithersburg, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Michael D. Culberson		22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute myocardial infarction</i>				Approximate Interval between Onset and Death Hours			
		b. <i>Arteriosclerotic heart disease</i>							
		c. <i>Arteriosclerotic vascular disease</i> years							
		d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ununalveolar Venous Thromboembolism</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John G. Lodewell MD</i>		29c. LICENSE NUMBER D05809				29d. DATE SIGNED (Month, Day, Year) ► 6-6-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John G. Lodewell MD, 2801 Olney Rd. Olney MD 20832</i>									
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE <i>John G. Lodewell</i>							

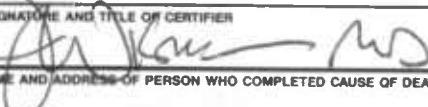
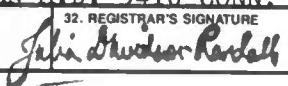


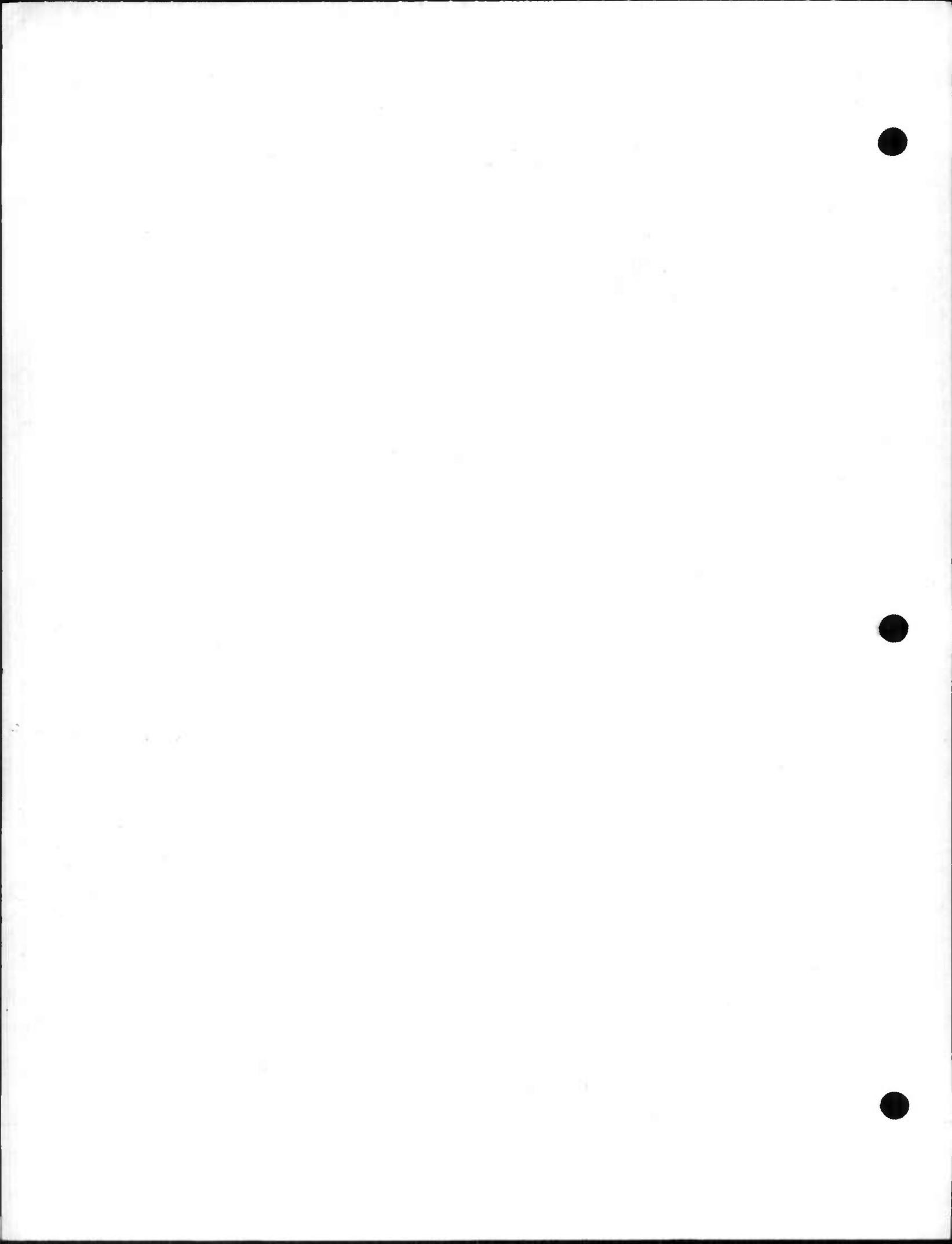
DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		JACK HERSON								2. DATE OF DEATH MONTH JUNE DAY 6, 1995 YEAR		3. TIME OF DEATH 12:30 P.M.	
4. SOCIAL SECURITY NUMBER 577-03-7741		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) NOV. 24, 1915		8. BIRTHPLACE (State or Foreign Country) WASH. D.C.	
9a. FACILITY NAME (If not institution, give street and number) CARRIAGE HILL BETHESSDA		9b. CITY, TOWN OR LOCATION OF DEATH BETHESSDA								9c. COUNTY OF DEATH MONT.			
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESSDA								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5450 WHITLEY PARK TERRACE		10f. ZIP CODE 20814								10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:								14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) AUTO EXECUTIVE		16b. KIND OF BUSINESS/INDUSTRY AUTO SALES MANAGER									
17. FATHER'S NAME (First, Middle, Last) MEYER HERSON		18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA SHORE											
19a. INFORMANT'S NAME (Type/Print) MYRA POLSKY (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6457 WISHBONE TERRACE-CABIN JOHN, MD 20818											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) BETH SHOLOM CEMETERY		DATE 6/7		20c. LOCATION — City or Town, State CAPITOL HEIGHTS, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MD 20852											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death ONE MONTH	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Cerebral vascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____ o. _____ p. _____ q. _____ r. _____ s. _____ t. _____ u. _____ v. _____ w. _____ x. _____ y. _____ z. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 12890											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29d. DATE SIGNED (Month, Day, Year) ► JUNE 6, 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JON M. WISEMAN M.D. 5410 CONN. AVE. N.W. #117 WASHINGTON, D.C. 20015													
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

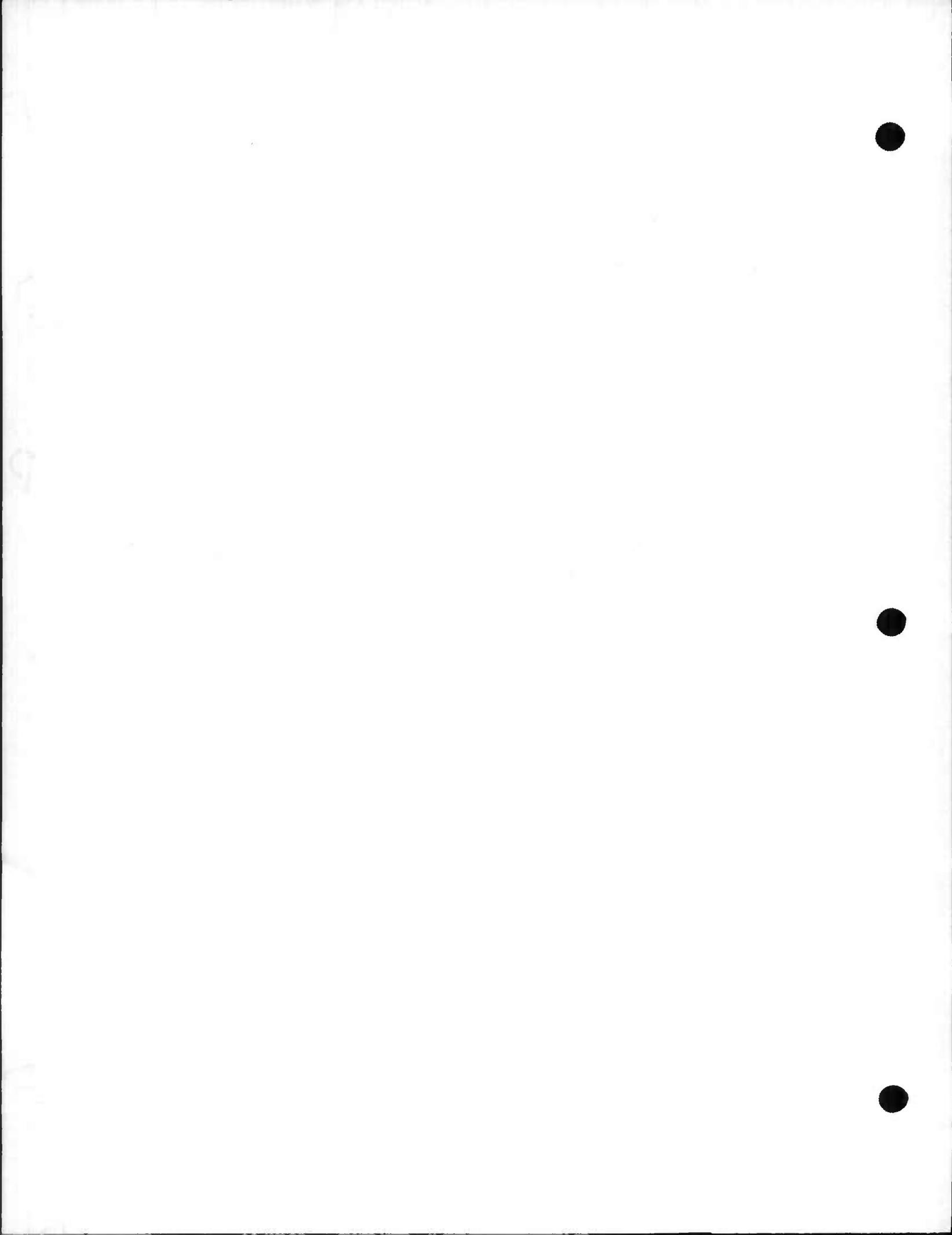
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19027

1. DECEDENT'S NAME (First, Middle, Last)		<i>JOHN G HOUGH</i>		2. DATE OF DEATH MONTH JUNE DAY 4 YEAR 95 0905A M	3. TIME OF DEATH								
4. SOCIAL SECURITY NUMBER 241-30-6979		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) October 21, 1925								
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		8. BIRTHPLACE (State or Foreign Country) North Carolina									
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Kensington			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
10e. STREET AND NUMBER 3333 University Blvd., West, Apt. 1203			10f. ZIP CODE 20895		10g. CITIZEN OF WHAT COUNTRY? USA								
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943 - 1962	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (D-12) 12	16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0	16. KIND OF BUSINESS/INDUSTRY Optometrist			16b. KIND OF BUSINESS/INDUSTRY Eye Care Industry								
17. FATHER'S NAME (First, Middle, Last) John G. Hough, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Annie McClees										
19e. INFORMANT'S NAME (Type/Print) Valerie Harshberger		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3333 University Blvd., West, Apt. 1203, Kensington, MD 20895											
20e. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory		DATE 6/15	20c. LOCATION — City or Town, State Brentwood, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John G. Hough</i>		22. NAME AND ADDRESS OF FACILITY Hines-Kinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <u>MYOCARDIAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <u>VALVULAR HEART DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p>													
Approximate Interval Between Onset and Death ACUTE INDCF													
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO													
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 1 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <table border="0"> <tr> <td>1 <input checked="" type="checkbox"/> Natural</td> <td>5 <input type="checkbox"/> Pending investigation</td> </tr> <tr> <td>2 <input type="checkbox"/> Accident</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Suicide</td> <td>8 <input type="checkbox"/> Could not be determined</td> </tr> <tr> <td>4 <input type="checkbox"/> Homicide</td> <td></td> </tr> </table>						1 <input checked="" type="checkbox"/> Natural	5 <input type="checkbox"/> Pending investigation	2 <input type="checkbox"/> Accident		3 <input type="checkbox"/> Suicide	8 <input type="checkbox"/> Could not be determined	4 <input type="checkbox"/> Homicide	
1 <input checked="" type="checkbox"/> Natural	5 <input type="checkbox"/> Pending investigation												
2 <input type="checkbox"/> Accident													
3 <input type="checkbox"/> Suicide	8 <input type="checkbox"/> Could not be determined												
4 <input type="checkbox"/> Homicide													
<p>26e. DATE OF INJURY (Month, Day, Year)</p> <p>26b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>26d. DESCRIBE HOW INJURY OCCURRED</p> <p>26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</p> <p>26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p>													
29e. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29f. SIGNATURE AND TITLE OF CERTIFIER <i>Francis C. Mayle</i>													
29g. LICENSE NUMBER 007099													
29h. DATE SIGNED (Month, Day, Year) JUNE 4 95													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis C. Mayle 10215 Fernwood Rd Bethesda Md 20817													
31. DATE FILED (Month, Day, Year) JUN 07 1995													
32. REGISTRAR'S SIGNATURE <i>Jane D. Harshberger-Kardell</i>													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

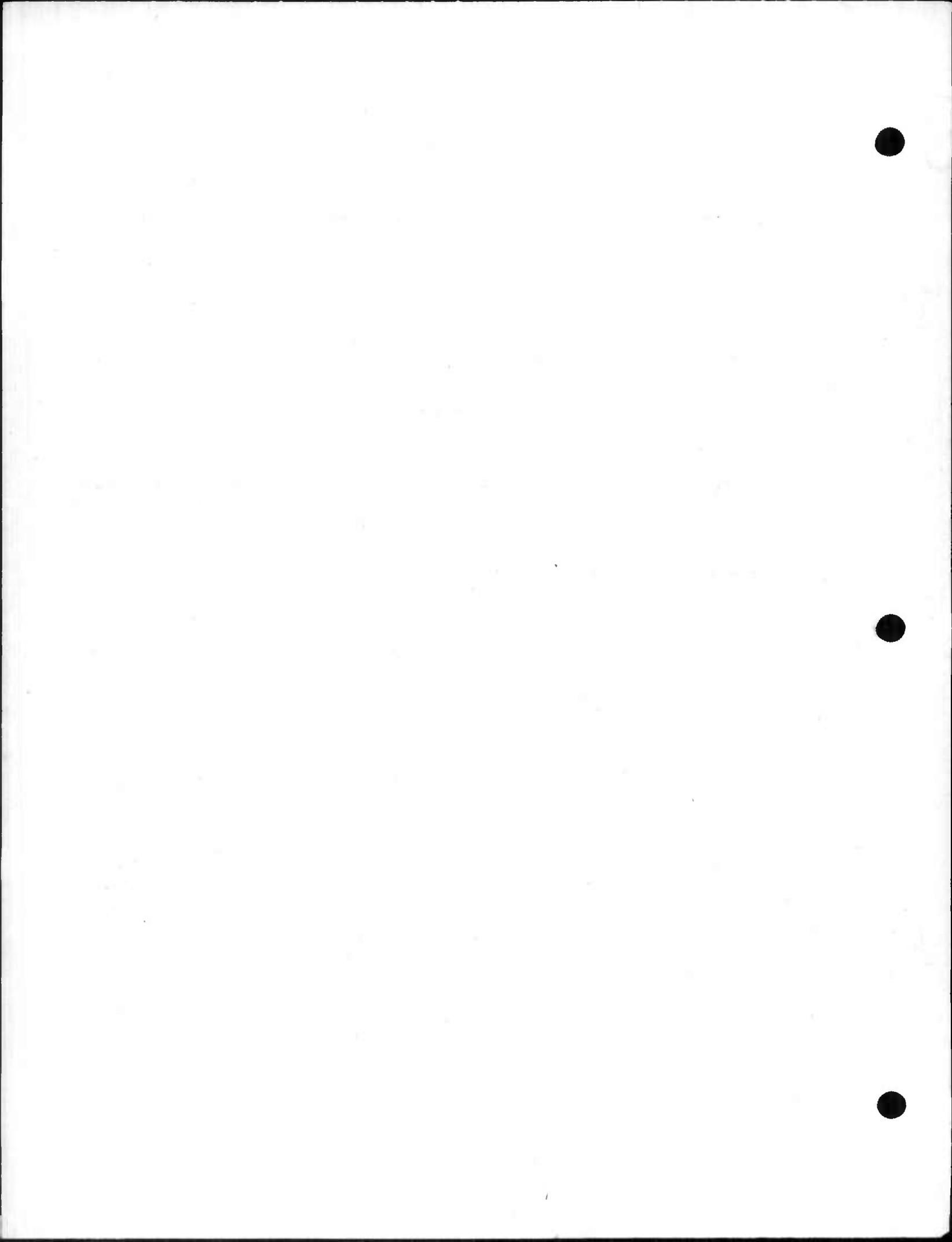
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		K. Cora Hess				2. DATE OF DEATH MONTH JUNE DAY 2 YEAR 1995		3. TIME OF DEATH 2:10 PM			
4. SOCIAL SECURITY NUMBER 233-26-3052		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 2, 1917			
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery			8. BIRTHPLACE (State or Foreign Country) West Virginia		
RESIDENCE OF DECEDENT											
10e. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Potomac				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 11814 Enid Drive				10f. ZIP CODE 20854			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) —		College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary			16b. KIND OF BUSINESS/INDUSTRY Department of Interior				
17. FATHER'S NAME (First, Middle, Last) John A. Hess				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Windom							
19a. INFORMANT'S NAME (Type/Print) Mary Lee Neal				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Edgelawn Avenue, Williamstown, West Virginia							
20e. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		DATE June 4, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dickie P. Katta</i>		M00348		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i>											
Approximate Interval Between Onset and Death 2 years											
b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i>											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		26e. DATE OF INJURY (Month, Day, Year)		26f. TIME OF INJURY M	26g. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	26d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Cora J. Alterberg, MD</i>		29c. LICENSE NUMBER D 26570		29d. DATE SIGNED (Month, Day, Year) ► June 2, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Paul L. Schoenberger 16220 Frederick Rd Gaithersburg</i>											
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE <i>Juli Hudson-Robell</i>									



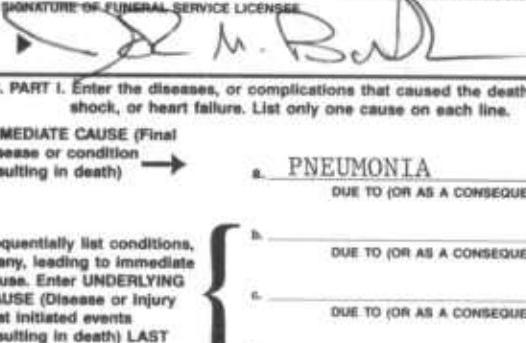
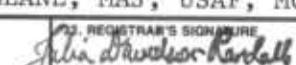
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be signed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

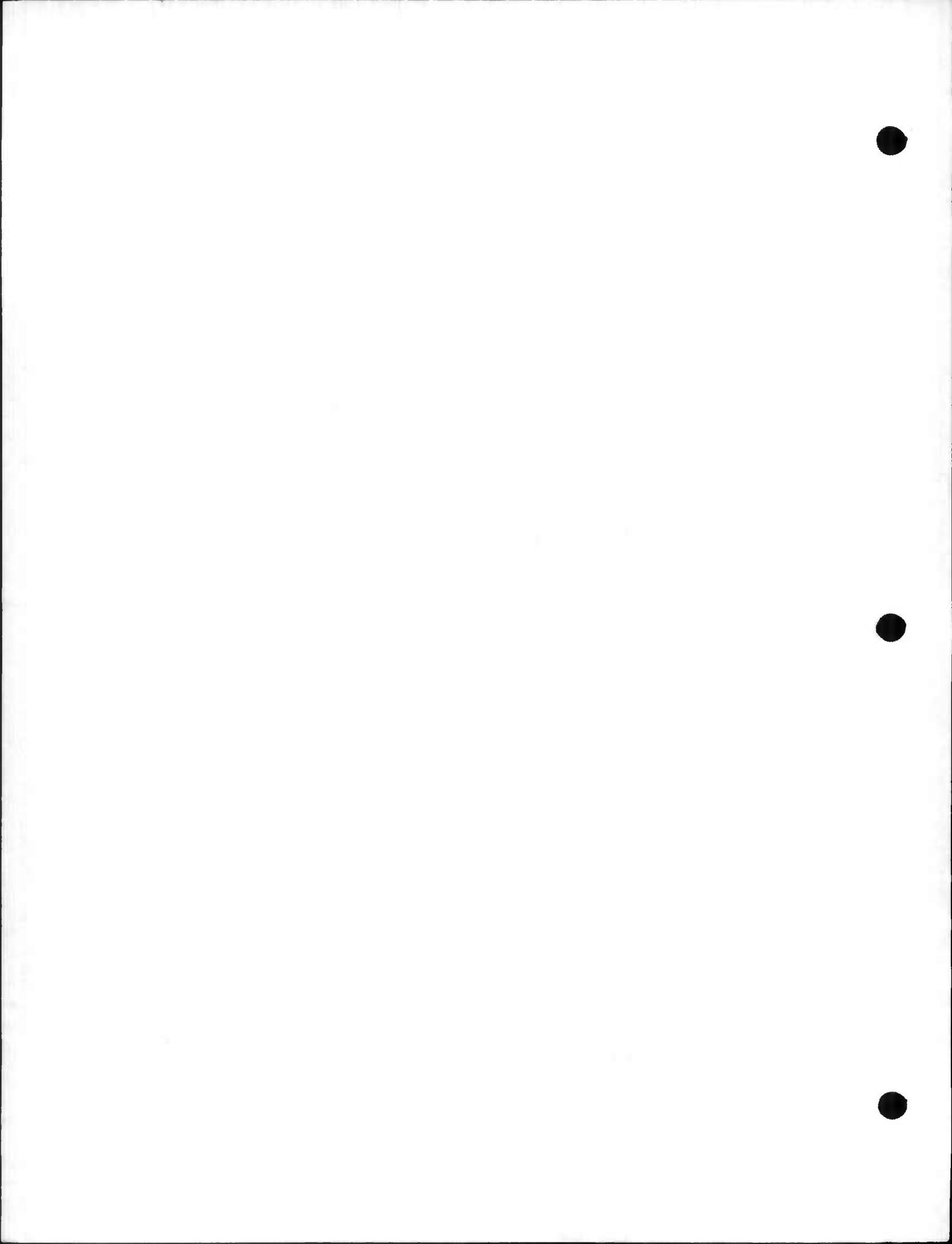
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) GEORGE ROBERT HERRMAN										2. DATE OF DEATH MONTH MAY DAY 21 YEAR 1995	3. TIME OF DEATH 7:48 am
4. SOCIAL SECURITY NUMBER 306 18 4423		5. SEX 1 ♂ M 2 ♀ F		6. AGE (In yrs. last birthday) 80 YRS.		7. IF UNDER 1 YEAR MONTHS 0 DAYS 0		8. IF UNDER 24 HRS. HOURS 0 MIN. 0		9. DATE OF BIRTH (Month, Day, Year) December 22, 1914	10. BIRTHPLACE (State or Foreign Country) Indiana
11. FACILITY NAME (If not institution, give street and number) Malcolm Grow Hospital										12. CITY, TOWN OR LOCATION OF DEATH Andrews Air Force Base	13. COUNTY OF DEATH Prince George
14. RESIDENCE OF DECEDENT 14a. STATE Virginia 14b. COUNTY Fairfax 14c. CITY, TOWN OR LOCATION Alexandria										14d. INSIDE CITY LIMITS? 1 ☐ YES 2 ☒ NO	
15a. STREET AND NUMBER 5903 Mt. Eagle Drive, #1514					15c. ZIP CODE 22303					16g. CITIZEN OF WHAT COUNTRY? USA	
15. MARITAL STATUS 1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced			15d. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 ☒ YES 2 ☐ NO IF YES, GIVE WAR OR DATES			15e. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ YES 2 ☒ NO Specify:			15f. RACE — American Indian, Black, White, etc. Specify: Caucasian		
15g. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			15h. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+ Officer			15i. KIND OF BUSINESS/INDUSTRY United States Air Force					
17. FATHER'S NAME (First, Middle, Last) George W. Herrman										18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Ross	
19a. INFORMANT'S NAME (Type/Print) John Herrman					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 508 N. Washington Street, Alexandria, VA 22314						
20a. METHOD OF DISPOSITION 1 ☐ Burial 2 ☒ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery 6/1					DATE	20c. LOCATION — City or Town, State Arlington, Virginia
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Demaine Funeral Homes, Inc. Alexandria, Virginia 22314						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PNEUMONIA											
DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 ☒ YES 2 ☐ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 ☐ YES 2 ☐ NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES ☐ NO ☐ UNCERTAIN ☐											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 ☐ YES 2 ☒ NO		26. PLACE OF DEATH (Check only one) 1 ☒ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify)									
27. MANNER OF DEATH 1 ☒ Natural 5 ☐ Pending investigation 2 ☐ Accident 6 ☐ Could not be determined 3 ☐ Suicide 4 ☐ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 ☐ YES 2 ☐ NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 ☒ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 ☐ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER MA 5887 NJ								29d. DATE SIGNED (Month, Day, Year) ► 21 MAY 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY J. SPILLANE, MAJ, USAF, MC		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB MD 20331-6600									
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE 									



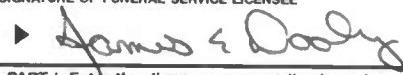
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

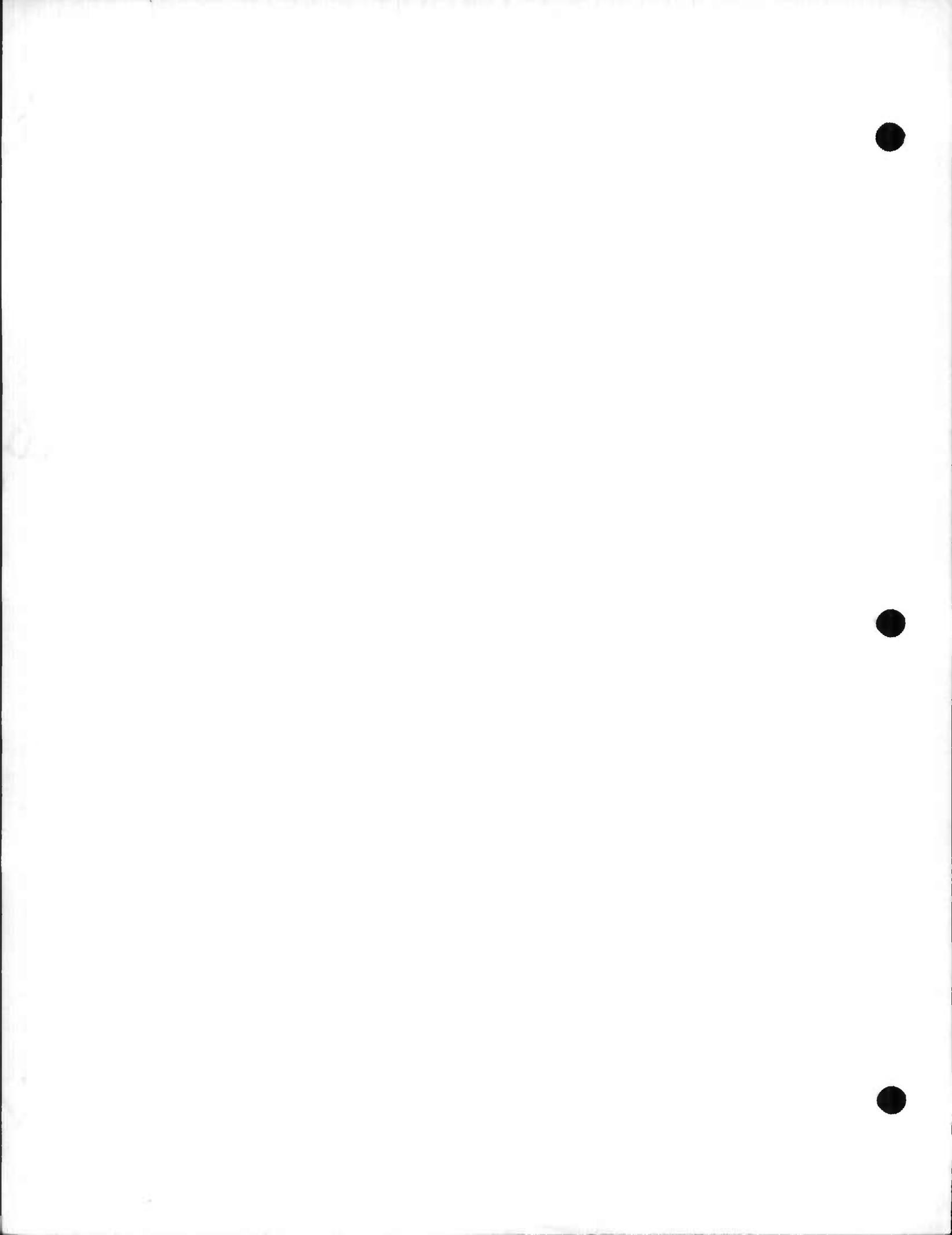
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR		Janet Mary Hyland								2. DATE OF DEATH MONTH DAY YEAR June 1 1995			
1. DECEDENT'S NAME (First, Middle, Last)		4. SOCIAL SECURITY NUMBER 577-46-2120		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		3. TIME OF DEATH 7A M			
9a. FACILITY NAME (If not institution, give street and number)		Suburban Hospital Bethesda								7. DATE OF BIRTH (Month, Day, Year) April 30, 1933			
RESIDENCE OF DECEDENT		Kensington								8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington								9c. COUNTY OF DEATH Montgomery	
10e. STREET AND NUMBER 9803 Cable Drive		10f. ZIP CODE 20895								10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Administrative Assistant				16b. KIND OF BUSINESS/INDUSTRY Labor Union							
17. FATHER'S NAME (First, Middle, Last) Lawrence A. Hyland		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Clark											
19a. INFORMANT'S NAME (Type/Print) John G. Clark		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 Vineyard Circle Stone Mountain, Georgia 30083											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery				DATE 6/3/95		20c. LOCATION — City or Town, State Silver Spring, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary hypertension DUE TO (OR AS A CONSEQUENCE OF): 3 months													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d.													
DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic renal insufficiency → renal failure Diabetes mellitus, hypertension													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 001119		29d. DATE SIGNED (Month, Day, Year) ► 6/1/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Fred A. Gill, M.D. 4743 Bradley Boulevard Chevy Chase, Maryland 20815		31. DATE FILED (Month, Day, Year) JUN 02 1995											
32. REGISTRAR'S SIGNATURE 													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

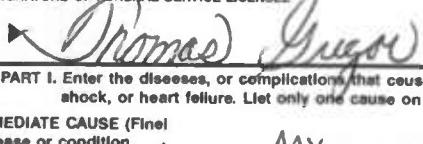
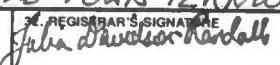
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

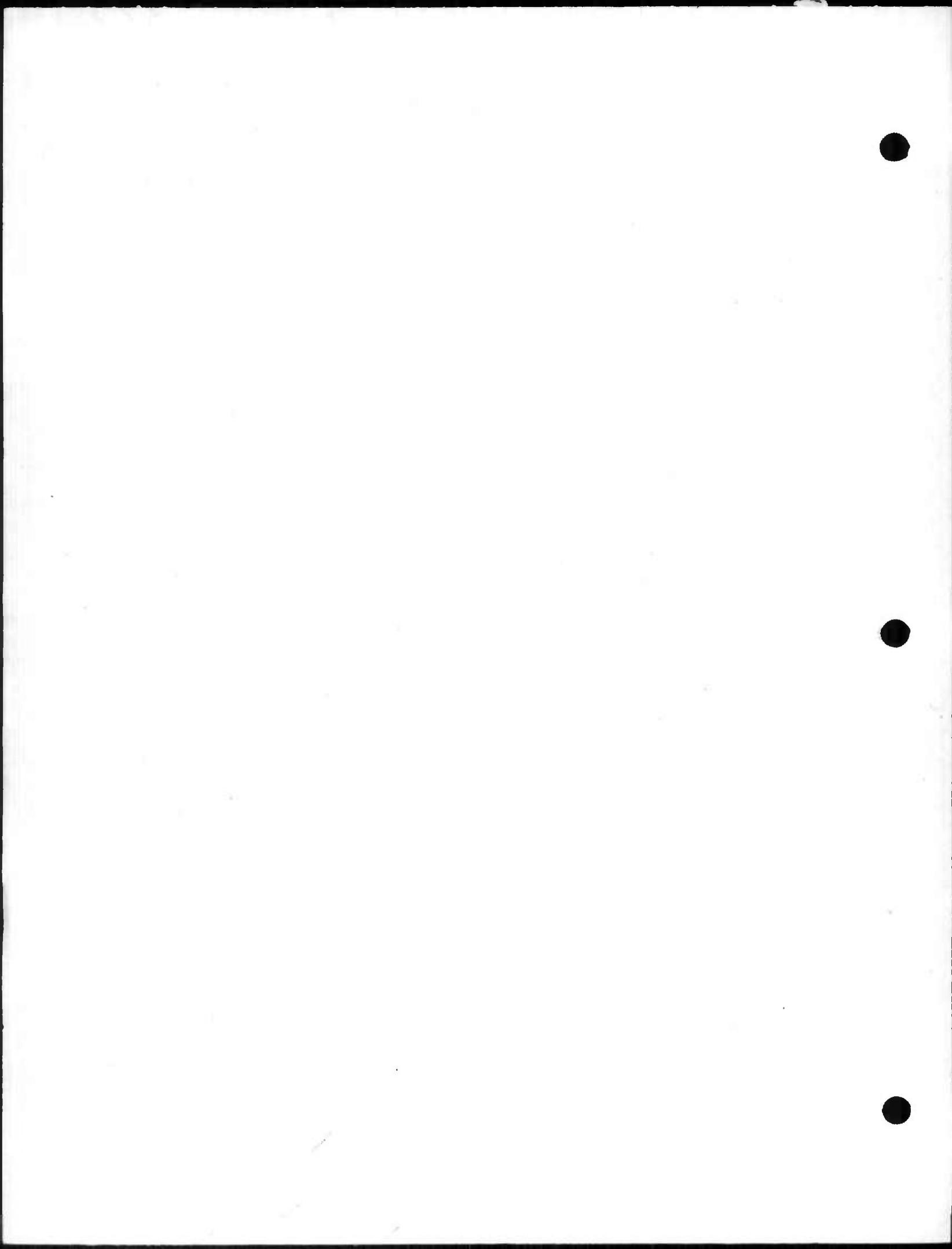
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or if Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

<i>Amended #6 6/6/95 MRT Montgomery County 95 19031</i> STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. _____											
1. DECEDENT'S NAME (First, Middle, Last) Mary Carolyn Hill											
4. SOCIAL SECURITY NUMBER 558-18-9110		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2. DATE OF DEATH MONTH DAY YEAR June 1, 1995		3. TIME OF DEATH 11:22 AM	
9a. FACILITY NAME (If not institution, give street and number) 2204 Greenery Lane, Apt. 101											
9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring											
9c. COUNTY OF DEATH Montgomery											
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 2204 Greenery Lane, Apt. 101				10f. ZIP CODE 20906				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO If Yes, give war or dates		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 12 2 Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Clarence Wilson				16. MOTHER'S NAME (First, Middle, Maiden Surname) Bernice Ellen Crawford							
19a. INFORMANT'S NAME (Type/Print) Carolyn E. Hill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1321 Alderton Lane, Silver Spring, Maryland 20906							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory		DATE 6/5		20c. LOCATION — City or Town, State Brentwood, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 											
22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904											
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 											
Approximate Interval Between Onset and Death ACUTE											
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <hr/>											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <hr/>			
28e. PLACE OF INJURY — At home, term, street, tactory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <hr/>									
29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 											
29c. LICENSE NUMBER DO 70 99											
29d. DATE SIGNED (Month, Day, Year) JUNE 1 95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C MAPLE 1045 FERNWOOD Rd BETHESDA MD 20817											
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

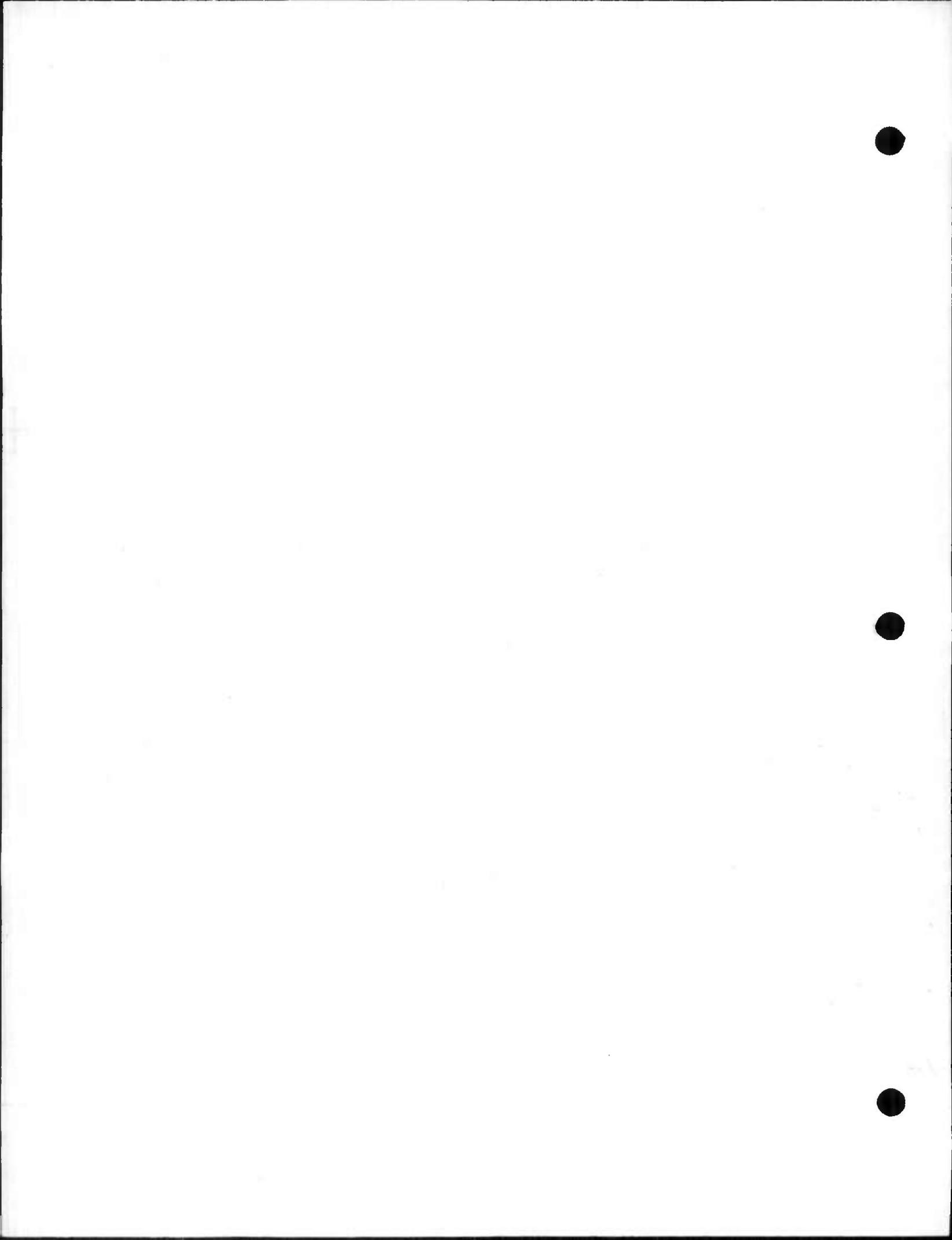
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR		Barbara Jean Hoheisel (AKA Thomas)								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 4:00 PM			
1. DECEDENT'S NAME (First, Middle, Last)		Barbara Jean Hoheisel (AKA Thomas)								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 4:00 PM			
4. SOCIAL SECURITY NUMBER 218-66-7893		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 35 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 21, 1959		8. BIRTHPLACE (State or Foreign Country) Virginia					
9e. FACILITY NAME (If not institution, give street and number) 10221 Oldfield Drive		9b. CITY, TOWN OR LOCATION OF DEATH Kensington								9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT															
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Kensington								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 10221 Oldfield Drive				10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Manager				16b. KIND OF BUSINESS/INDUSTRY Telecommunications									
17. FATHER'S NAME (First, Middle, Last) Robert A. Hoheisel					18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Nemeth										
19e. INFORMANT'S NAME (Type/Print) Robert A. Hoheisel					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10114 Crestwood Road, Kensington, Maryland 20895										
20e. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				DATE		20c. LOCATION — City or Town, State Bethesda, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSER ► Michael E. Higgins MO0846															
22. NAME AND ADDRESS OF FACILITY Robert A. Lumprey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue Bethesda, Maryland 20814-3501															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Brain Stem Glioma DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____															
Approximate Interval Between Onset and Death 4 Years															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO															
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Jeremy V. Cooke, M.D.		29c. LICENSE NUMBER D04602				29d. DATE SIGNED (Month, Day, Year) ► June 5, 1995				20895-3910					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeremy V. Cooke, M.D., 10400 Connecticut Avenue #606, Kensington, Maryland															
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE Julie Annmarie Marshall													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

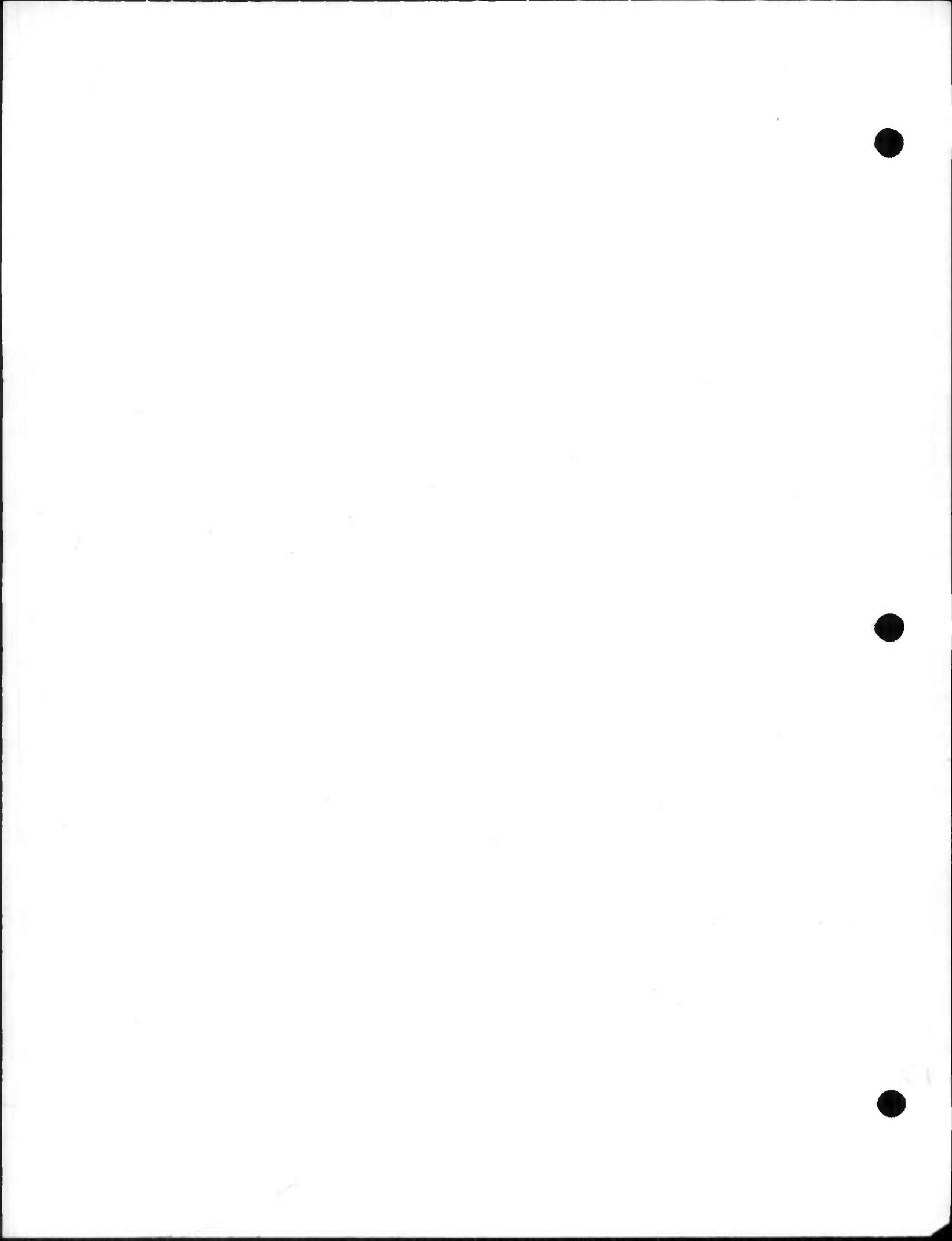
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19033

1. DECEDENT'S NAME (First, Middle, Last) Terese H. Hoadley						2. DATE OF DEATH MONTH DAY YEAR June 3, 1995	3. TIME OF DEATH 9:50P M		
4. SOCIAL SECURITY NUMBER 392-01-0001			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		7. DATE OF BIRTH (Month, Day, Year) Dec. 19, 1918	8. BIRTHPLACE (State or Foreign Country) Wisconsin	
9a. FACILITY NAME (If not Institution, give street and number) 6 Sunnymeade Court						9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT									
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 6 Sunnymeade Court				10f. ZIP CODE 20854			10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES -			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) - College (14 or 5+) 4			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accountant			16b. KIND OF BUSINESS/INDUSTRY US Government			
17. FATHER'S NAME (First, Middle, Last) Frank Hussli					18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Schwager				
19a. INFORMANT'S NAME (Type/Print) Danielle A. Hoadley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6 Sunnymeade Court, Rockville, Maryland 20854					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) June 6, 1995 Gate of Heaven Cemetery			DATE June 6, 1995	20c. LOCATION — City or Town, State Silver Spring, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michele J. Kutto				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Ovarian Cancer									
Approximate interval Between Onset and Death One year									
<p>b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):</p>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFY <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one)			29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29c. SIGNATURE AND TITLE OF CERTIFIER Kenneth Miller, MD			29d. LICENSE NUMBER 033686			29e. DATE SIGNED (Month, Day, Year) ► June 5, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kenneth Miller, MD 1811 Prince Philip Dr. Olney, MD 20832									
31. DATE FILED (Month, Day, Year) JUN 06 1995			32. REGISTRAR'S SIGNATURE Julia Davidson Randall						



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

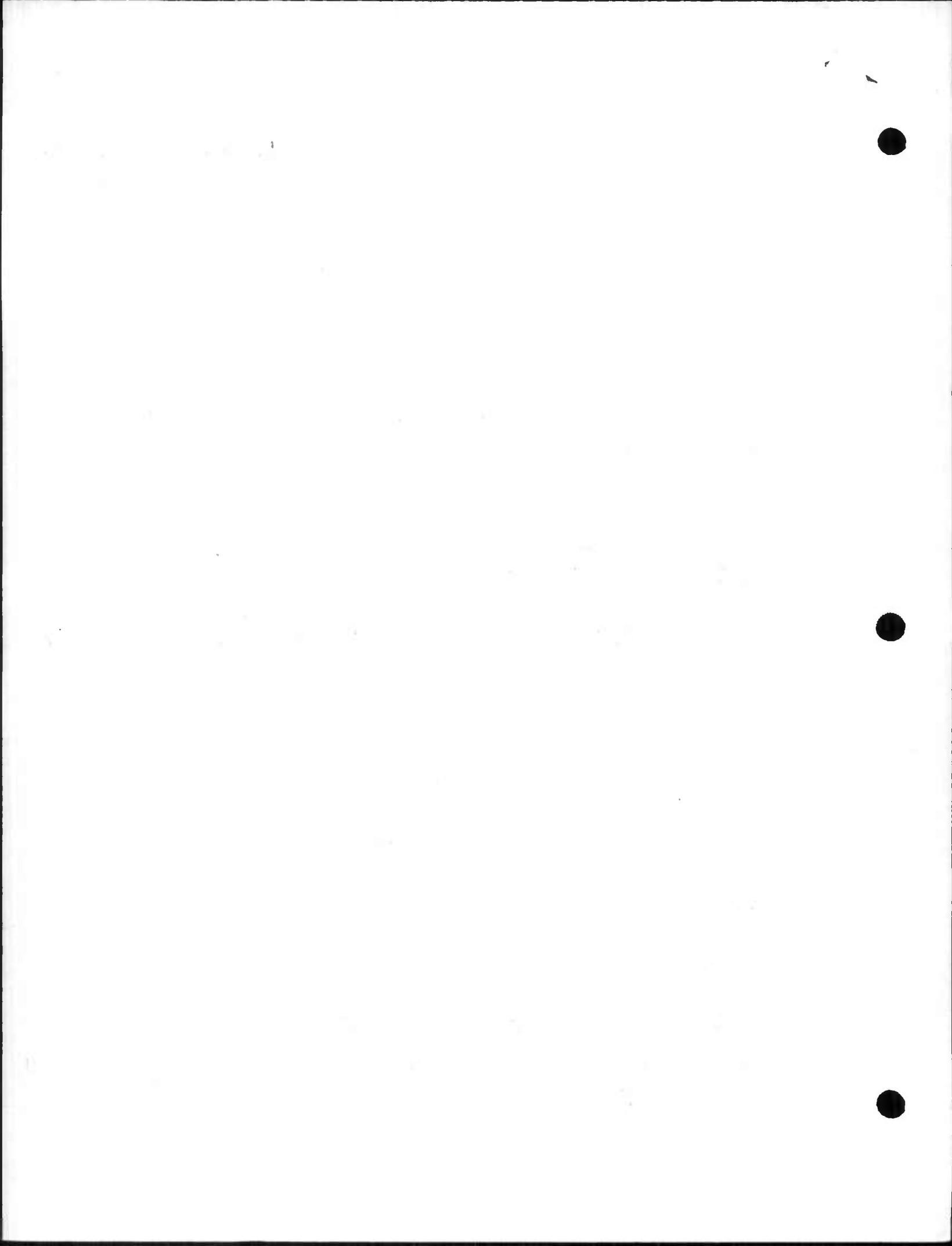
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR																	
1. DECEDENT'S NAME (First, Middle, Last) Laura Marie Hyde												2. DATE OF DEATH June 11, 1995	3. TIME OF DEATH 2:55 P.M.				
4. SOCIAL SECURITY NUMBER 212-32-3975			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTHS		DAYS		HOURS		MIN.		
9e. FACILITY NAME (If not institution, give street and number) Brookfield Manor Resident Care			9b. CITY, TOWN OR LOCATION OF DEATH Middleburg														
RESIDENCE OF DECEDENT			9c. COUNTY OF DEATH Carroll														
10a. STATE Maryland	10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Union Bridge												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 210 Penrose Ave.												10f. ZIP CODE 21791	10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) owner/operator			16b. KIND OF BUSINESS/INDUSTRY restaurant											
17. FATHER'S NAME (First, Middle, Last) Lewis E. Green												16. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Baile					
19a. INFORMANT'S NAME (Type/Print) Bonnie M. Hyde			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 210 Penrose Ave. Union Bridge, MD 21791														
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pipe Creek Cemetery			DATE 6/14		20c. LOCATION — City or Town, State nr. Linwood, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Catherine O. Hartzler						22. NAME AND ADDRESS OF FACILITY D.D. Hartzler & Sons											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma left breast → Bone DUE TO (OR AS A CONSEQUENCE OF):												Approximate Interval Between Onset and Death 1986					
b. DUE TO (OR AS A CONSEQUENCE OF):																	
c. DUE TO (OR AS A CONSEQUENCE OF):																	
d. DUE TO (OR AS A CONSEQUENCE OF):																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Aortic stenosis												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29b. SIGNATURE AND TITLE OF CERTIFIER J.H. Caricope MD			29c. LICENSE NUMBER D 906			29d. DATE SIGNED (Month, Day, Year) ► 6/11/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 23) (Type, Print) R.J.-H. Caricope MD F.D.Bx 1110 Union Bridge, MD 21791																	
31. DATE FILED (Month, Day, Year) JUN 12 1995			32. REGISTRAR'S SIGNATURE John H. Hartzler														



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

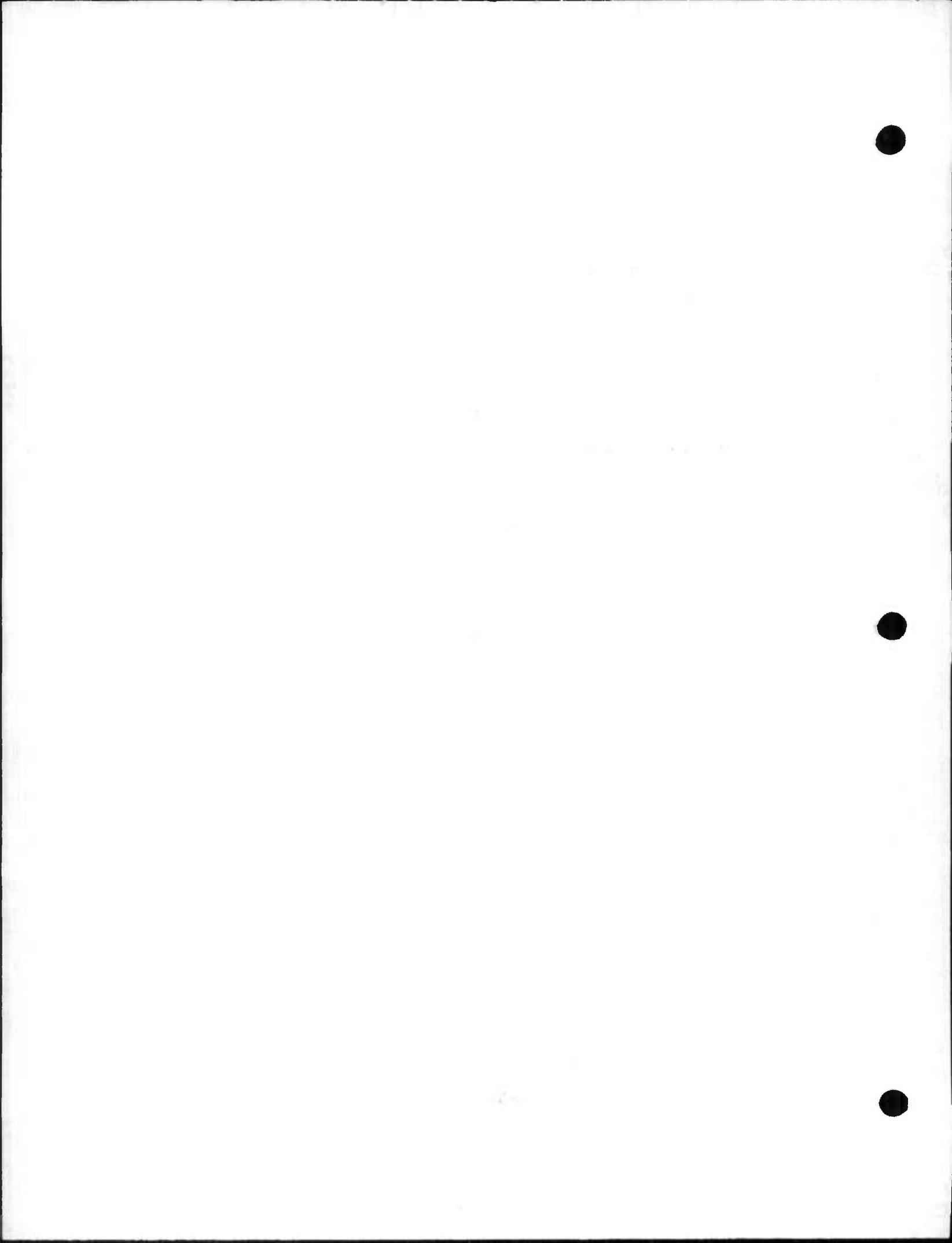
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19035

1. DECEDENT'S NAME (First, Middle, Last) Frances W. Harper						2. DATE OF DEATH MONTH DAY YEAR June 1, 1995	3. TIME OF DEATH 9:00 A. M.	
4. SOCIAL SECURITY NUMBER 243-56-9371			5. SEX M	6. AGE (In yrs. last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7. DATE OF BIRTH (Month, Day, Year) 9-19-37	8. BIRTHPLACE (State or Foreign Country) North Carolina
9a. FACILITY NAME (If not institution, give street and number) 607 Rosier Road			9b. CITY, TOWN OR LOCATION OF DEATH Fort Washington				9c. COUNTY OF DEATH Prince George's	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Fort Washington				10d. INSIDE CITY LIMITS? YES
10e. STREET AND NUMBER 607 Rosier Road				10f. ZIP CODE 20744			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS Never Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES A			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO			14. RACE — American Indian, Black, White, etc. White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Relocation Director			16b. KIND OF BUSINESS/INDUSTRY Nyman Real Estate			
17. FATHER'S NAME (First, Middle, Last) Johnnie Buck Williams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lorena Wright				
19a. INFORMANT'S NAME (Type/Print) W. Harold Harper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 607 Rosier Rd. Ft. Washington, Md. 20744				
20a. METHOD OF DISPOSITION Burial			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rocky Mount Memorial Park			DATE 6/4/95	20c. LOCATION — City or Town, State Rocky Mount, N. Carolina	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey Hines			22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. Acute cardiopulmonary failure DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. terminal advanced recurrent ovarian cancer DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. </p>								
Approximate Interval Between Onset and Death								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
					24a. WAS AN AUTOPSY PERFORMED? NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO		
					1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH Natural		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 1	28d. DESCRIBE HOW INJURY OCCURRED		
1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/>		5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) Certifying Physician		29c. LICENSE NUMBER DC 19494						
29b. SIGNATURE AND TITLE OF CERTIFIER Jeffrey Hines		29d. DATE SIGNED (Month, Day, Year) June 2, 1995						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jeffrey Hines, M.D. 3800 Reservoir Rd., N. W. Washington, D.C. 20007								
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE Julia Davidson-Hines						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

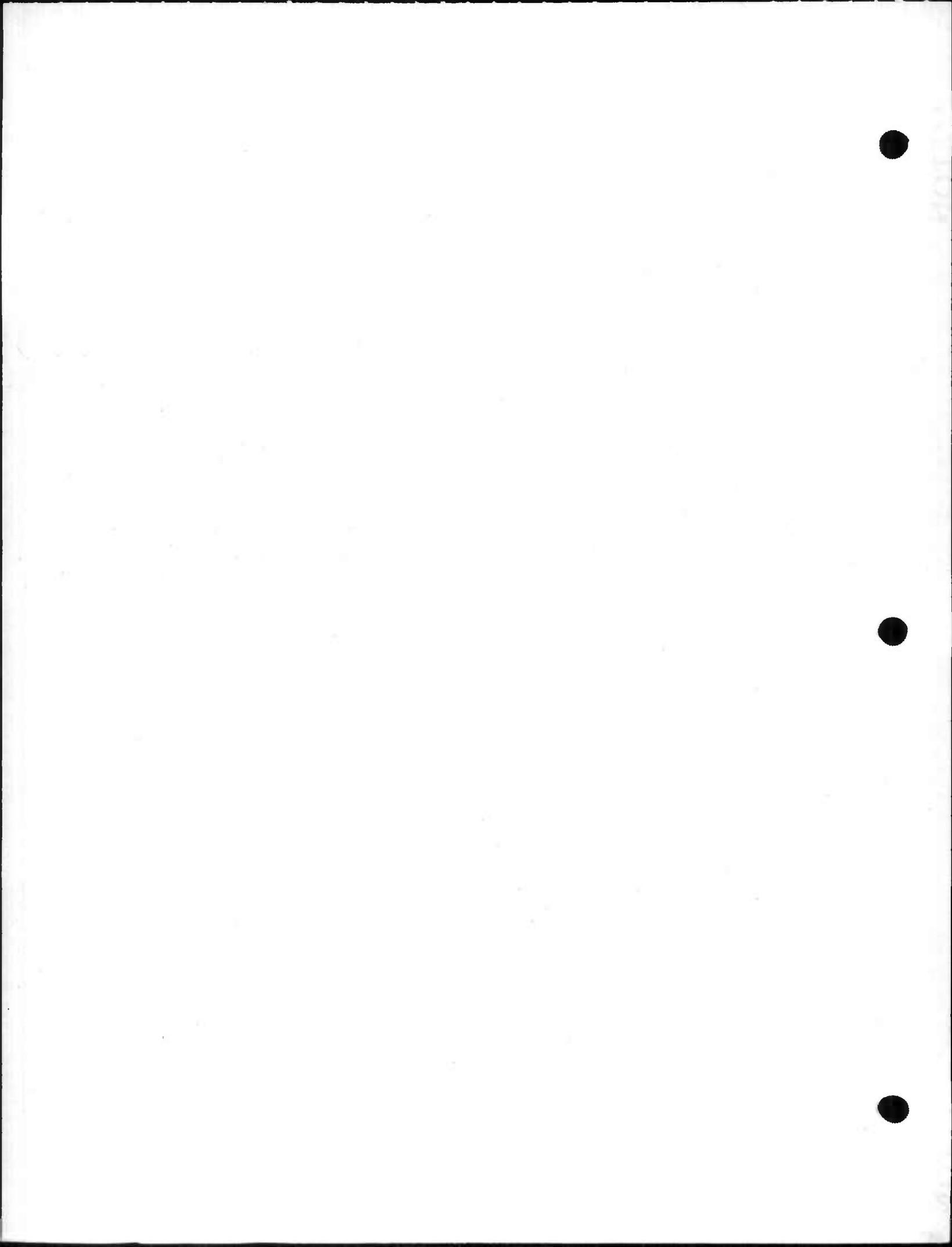
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, name 5 should be detached for use as the burial-transect permit. Boxes 1, 2, 3 should

1 - FOR
STATE
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LEE JOHN HORNING						2. DATE OF DEATH MONTH DAY YEAR June 4, 1995	3. TIME OF DEATH 3:55 A M
4. SOCIAL SECURITY NUMBER 086-18-2814		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) June 23, 1924	8. BIRTHPLACE (State or Foreign Country) New York
9e. FACILITY NAME (If not institution, give street and number) 2402 59th Place				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Cheverly			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2414 59th Place				10f. ZIP CODE 20785		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Elementary/Secondary (0-12) College (1-4 or 5+) 2		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Engineer		16b. KIND OF BUSINESS/INDUSTRY Space Industry			
17. FATHER'S NAME (First, Middle, Last) John Horning				18. MOTHER'S NAME (First, Middle, Maiden Surname) Addie L. Tryon			
19a. INFORMANT'S NAME (Type/Print) Terry L. Horning				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6103 Forest Road, Cheverly, Maryland 20785			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 06/07/95		DATE	20c. LOCATION — City or Town, State Alexandria, Virginia		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC LYMPHOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____ Approximate interval Between Onset and Death Unknown							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE NOW INJURY OCCURED 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D24093		29d. DATE SIGNED (Month, Day, Year) ► 6/7/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Parkhurst, M.D. 7305 Baltimore Avenue, #107, College Park, MD 20740-3232							
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE Julia D'Amato-Hardaway					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

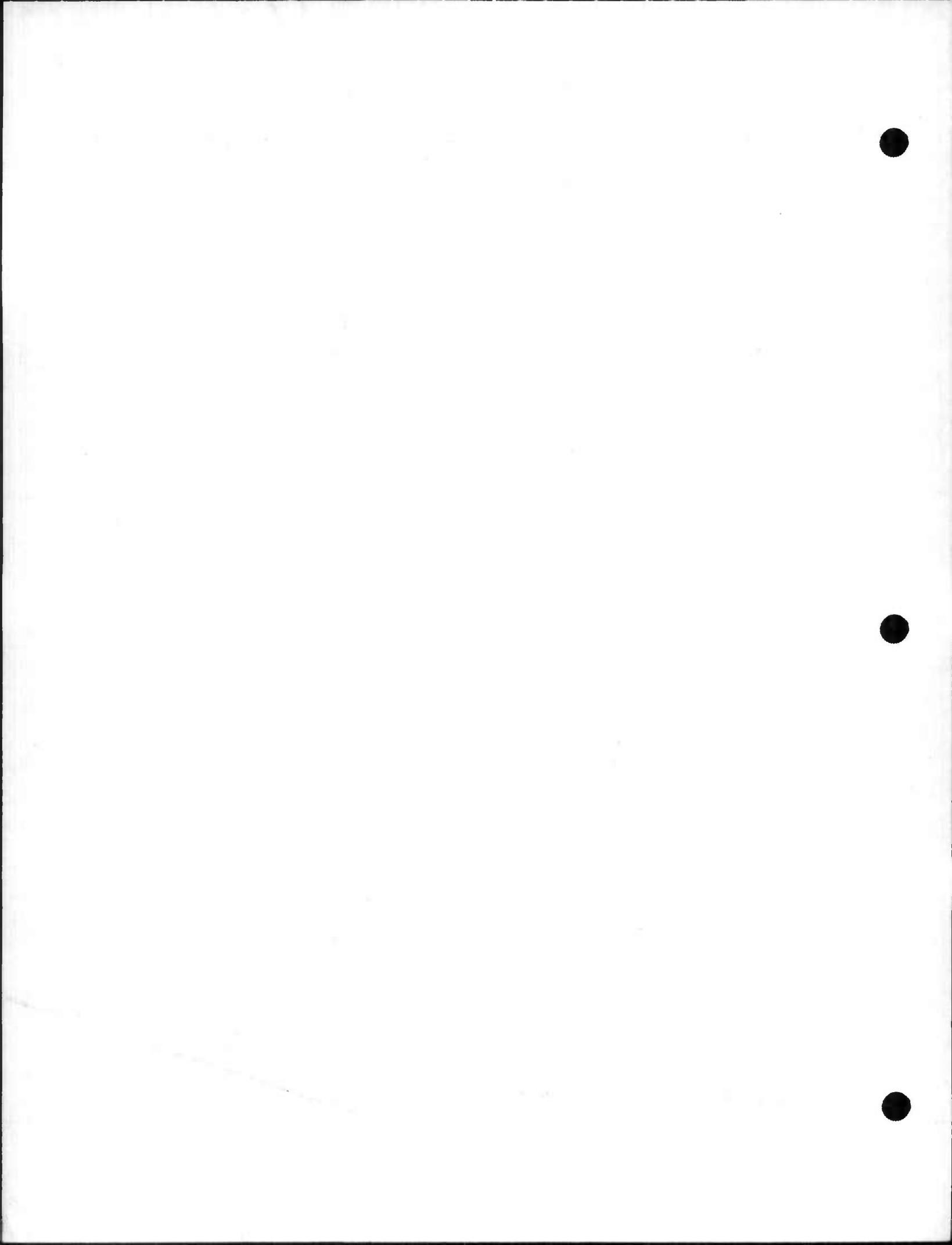
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)			Agnes Hodge						2. DATE OF DEATH May 22, 1995			3. TIME OF DEATH 11:29A				
4. SOCIAL SECURITY NUMBER 578-14-0432			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH Oct. 13, 1915			8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH LANHAM						9c. COUNTY OF DEATH PRINCE GEORGE'S							
RESIDENCE OF DECEDENT																
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Landover						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 6613 West Forest Road, #101				10f. ZIP CODE 20785					10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HouseKeeper				16b. KIND OF BUSINESS/INDUSTRY Private									
17. FATHER'S NAME (First, Middle, Last) DAVID SMITH					18. MOTHER'S NAME (First, Middle, Maiden Surname) NELLIE WILLIAMS											
19a. INFORMANT'S NAME (Type/Print) John Berry Sr.					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6357 64th Avenue, #E2, Riverdale, Maryland 20737											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery				DATE 6-6		20c. LOCATION — City or Town, State Arlington, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Juawana d. Braxton</i>																
22. NAME AND ADDRESS OF FACILITY J.B. Jenkins Funeral Home 7474 Landover Road, Landover, MD 20785																
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																
a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):																
b. ASPIRATION PNEUMONIA. DUE TO (OR AS A CONSEQUENCE OF):																
c. ASTHMA. DUE TO (OR AS A CONSEQUENCE OF):																
d. COPD. DUE TO (OR AS A CONSEQUENCE OF):																
Approximate Interval Between Onset and Death ONE DAY ONE DAY 30-min Years																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HTN; RENAL INSUFFICIENCY;</i>																
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <i>N/A</i>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Patient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide					28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
					28e. PLACE OF INJURY — At home, farm, street, laundry, office (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. SIGNATURE AND TITLE OF CERTIFIER <i>S.J. Rao, MD</i>								29c. LICENSE NUMBER D-34525		29d. DATE SIGNED (Month, Day, Year) ► 05/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 28) (Type/Print) <i>S.J. Rao, MD - 4000-Mitchellville Road, #220; Bowie-MD-20716.</i>																
31. DATE FILED (Month, Day, Year) May 06 1995					32. REGISTRAR'S SIGNATURE <i>Jahn Shuster-Randall</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

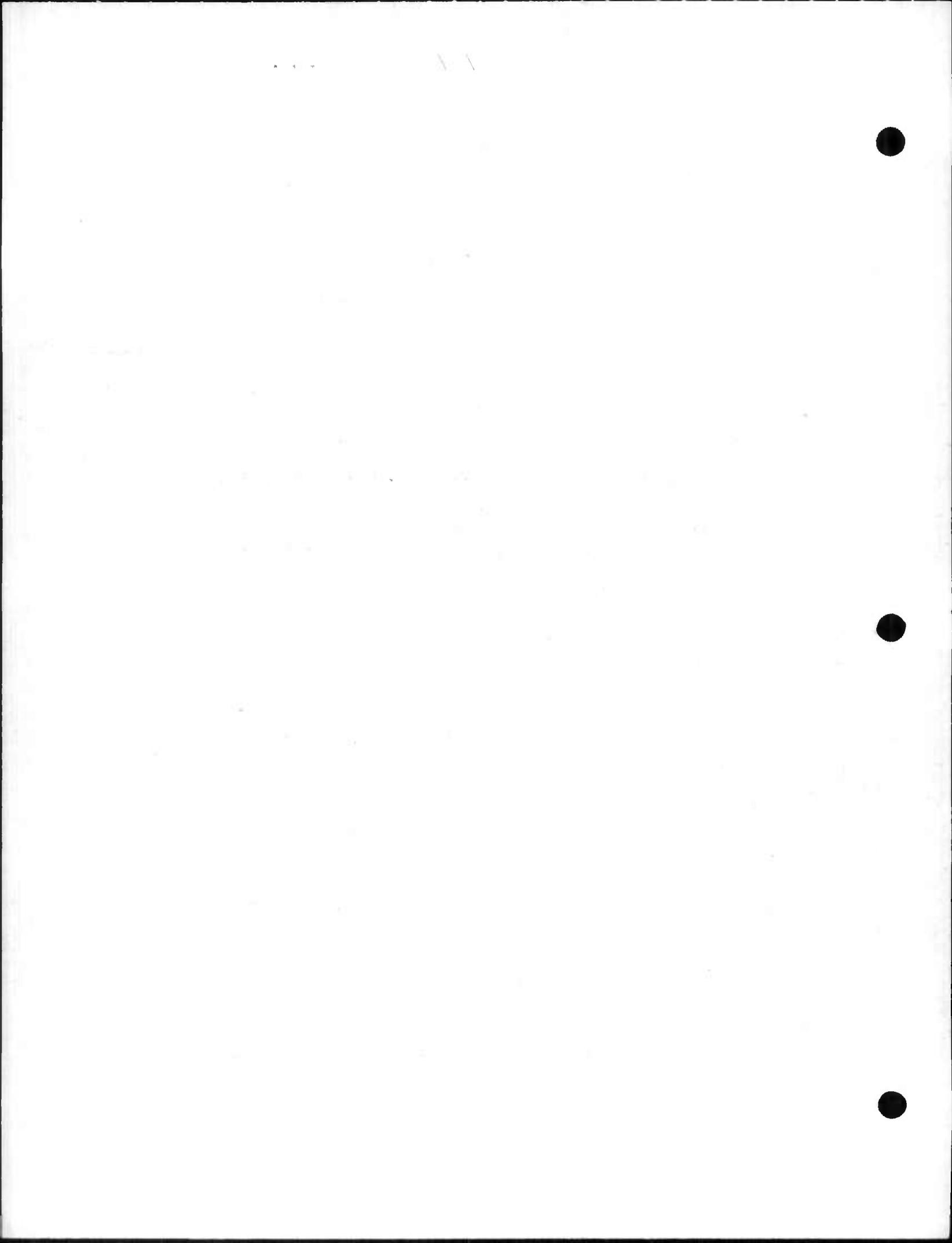
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
Myrtis Harris												May 29 1995 1810 M			
4. SOCIAL SECURITY NUMBER 215-54-9075		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) August 11, 1948		8. BIRTHPLACE (State or Foreign Country) North Carolina					
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER P.O. Box 6713												10f. ZIP CODE 20916		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. American Indian Caucasian									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Clerk		16b. KIND OF BUSINESS/INDUSTRY Data Measurement Corp.											
17. FATHER'S NAME (First, Middle, Last) Clarence Evans												18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Richardson			
19a. INFORMANT'S NAME (Type/Print) Colmorene E. Wilson												19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12240 Viers Mill Road, Wheaton, MD 20906			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Bethel Baptist Church Cemetery		DATE 6/3/95		20c. LOCATION — City or Town, State Warrenton, NC									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 												22. NAME AND ADDRESS OF FACILITY Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Approximate Interval Between Onset and Death			
s. <u>MULTIPLE INJURIES</u> DUE TO (OR AS A CONSEQUENCE OF):															
b. _____ DUE TO (OR AS A CONSEQUENCE OF):															
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)		OTHER: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 5-29-94		28b. TIME OF INJURY 5:00 PM	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED DRIVER Augo vs Auto Impact			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MD BELL PRE RD & LAYHILL, SILVER SPRING													
29e. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. SIGNATURE AND TITLE OF CERTIFIER 		29g. LICENSE NUMBER O.C.M.E.		29h. DATE SIGNED (Month, Day, Year) May 30 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark F. Gould Jr. MD		31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE John W. Randall		DHMH-16 Rev 1/89									
111 Penn Street, Baltimore Maryland 21201															



DIVISION OF VITAL RECORDS, P.O. BOX 68760

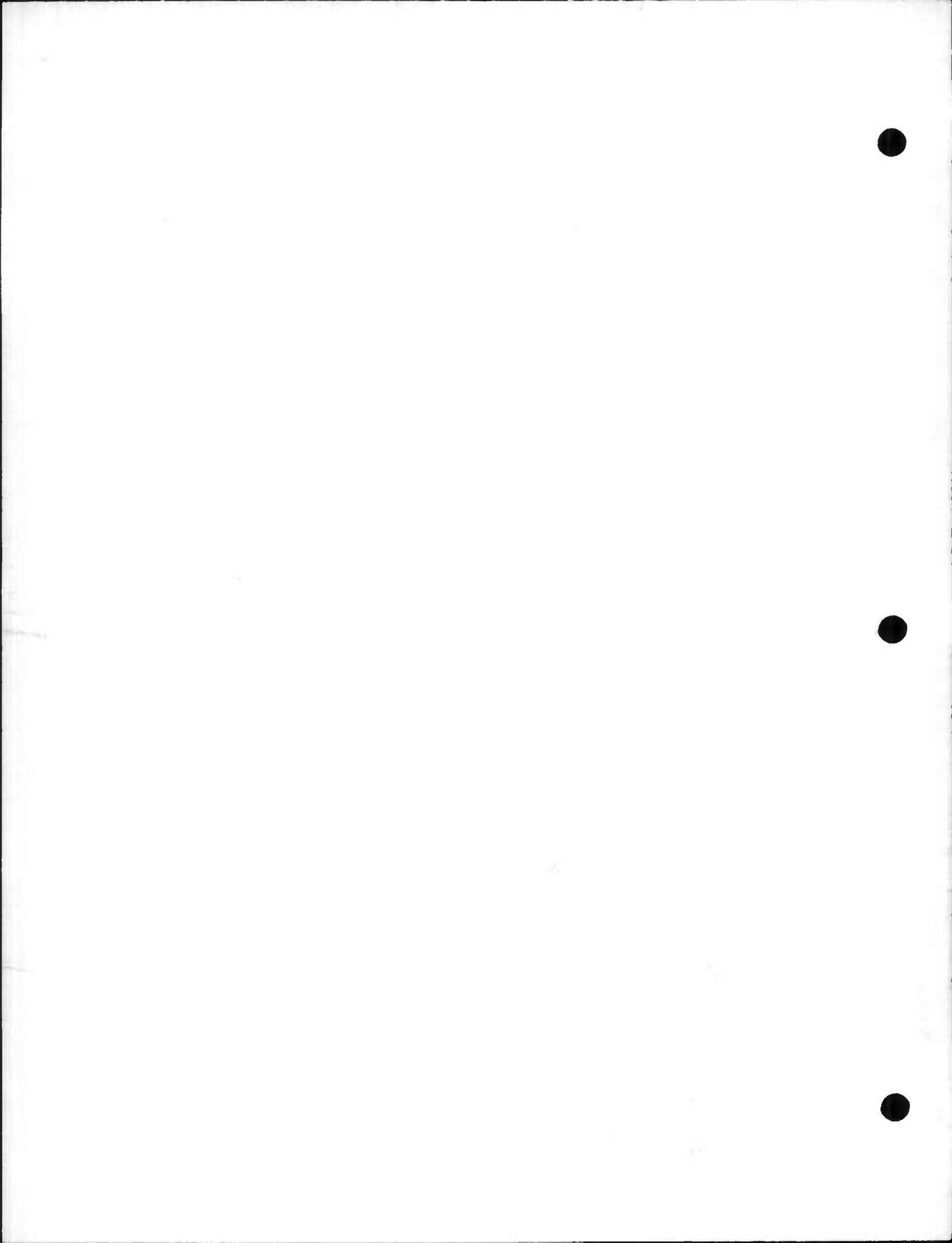
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		JACK EDGAR HORTON						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 235-38-5389		S. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 15, 1926		8. BIRTHPLACE (State or Foreign Country) Charlestown, WV	
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH Clinton						9c. COUNTY OF DEATH PRINCE GEORGE'S				
10e. STATE NA		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Washington, D.C.						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 3212 30th Street, S.E.								10f. ZIP CODE 20032		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 08/25/44		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Postal Clerk		16b. KIND OF BUSINESS/INDUSTRY US Post Office								
17. FATHER'S NAME (First, Middle, Last) Romero Jack Horton		18. MOTHER'S NAME (First, Middle, Maiden Surname) Hattie Pate										
19e. INFORMANT'S NAME (Type/Print) Hilda M. Smith/friend		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5105 Doppler St. Capital Heights, Md. 20743										
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Nat'l Harmony Memorial Pk		DATE 05/26/95		20c. LOCATION — City or Town, State Landover, Md.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Denly</i>		22. NAME AND ADDRESS OF FACILITY Robert G. Mason Funeral Home, Inc. 1661 Good Hope Rd., SE Wash., DC 20020										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Approximate Interval Between Onset and Death moments										
a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												
b. VENTRICULAR FIBRILLATION/ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF):		moments										
c. END-STAGE RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF):		years										
d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify):										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Berger MD (COMET)</i>		29c. LICENSE NUMBER D25925						29d. DATE SIGNED (Month, Day, Year) ► May 19, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 WISCONSIN Ave. Bethesda, Md 20814												
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE <i>John Dawson-Kerst</i>										



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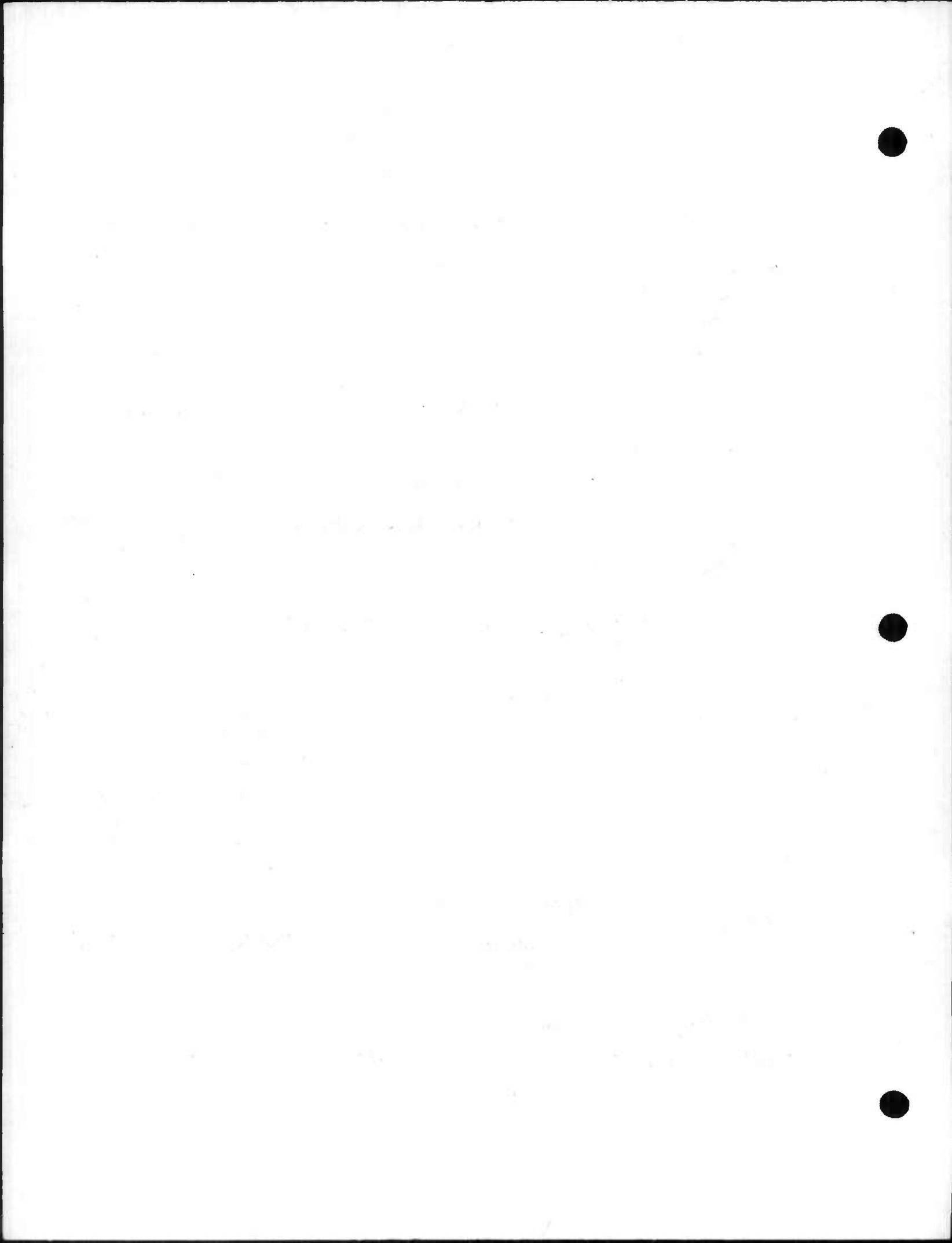
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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ANTHONY ALFONZO HARDY						2. DATE OF DEATH MONTH DAY YEAR June 04 1995	3. TIME OF DEATH M 1832
4. SOCIAL SECURITY NUMBER 578-94-9907		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) FEB 22, 1973	8. BIRTHPLACE (State or Foreign Country) WASH., D.C.	
8a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	9c. COUNTY OF DEATH Montgomery
10e. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION SILVER SPRING		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9124 PINEY BRANCH ROAD				10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES None		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: BLACK		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) FRANCIS V. SMITH				18. MOTHER'S NAME (First, Middle, Maiden Surname) DELORES HARDY			
19a. INFORMANT'S NAME (Type/Print) DELORES HARDY (MOTHER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1758 EAST WEST HIGHWAY, SILVER SPRING, MD 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) None		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LINCOLN MEMORIAL CEMETERY		DATE 6/9	20c. LOCATION — City or Town, State SUITLAND, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Alex S. Pope Jr.				22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Gunshot Wound of Chest DUE TO (OR AS A CONSEQUENCE OF): a. Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: X 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Street					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY 6/4/95		28b. TIME OF INJURY 1803 HR	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED Subject shot self	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Street		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 300 Block 6th Avenue Takoma Park, Maryland					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Theodore M. King					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King		31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE John Hudson-Randall		29c. LICENSE NUMBER O.C.M.E.	
29d. DATE SIGNED (Month, Day, Year) ► June 05 1995							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

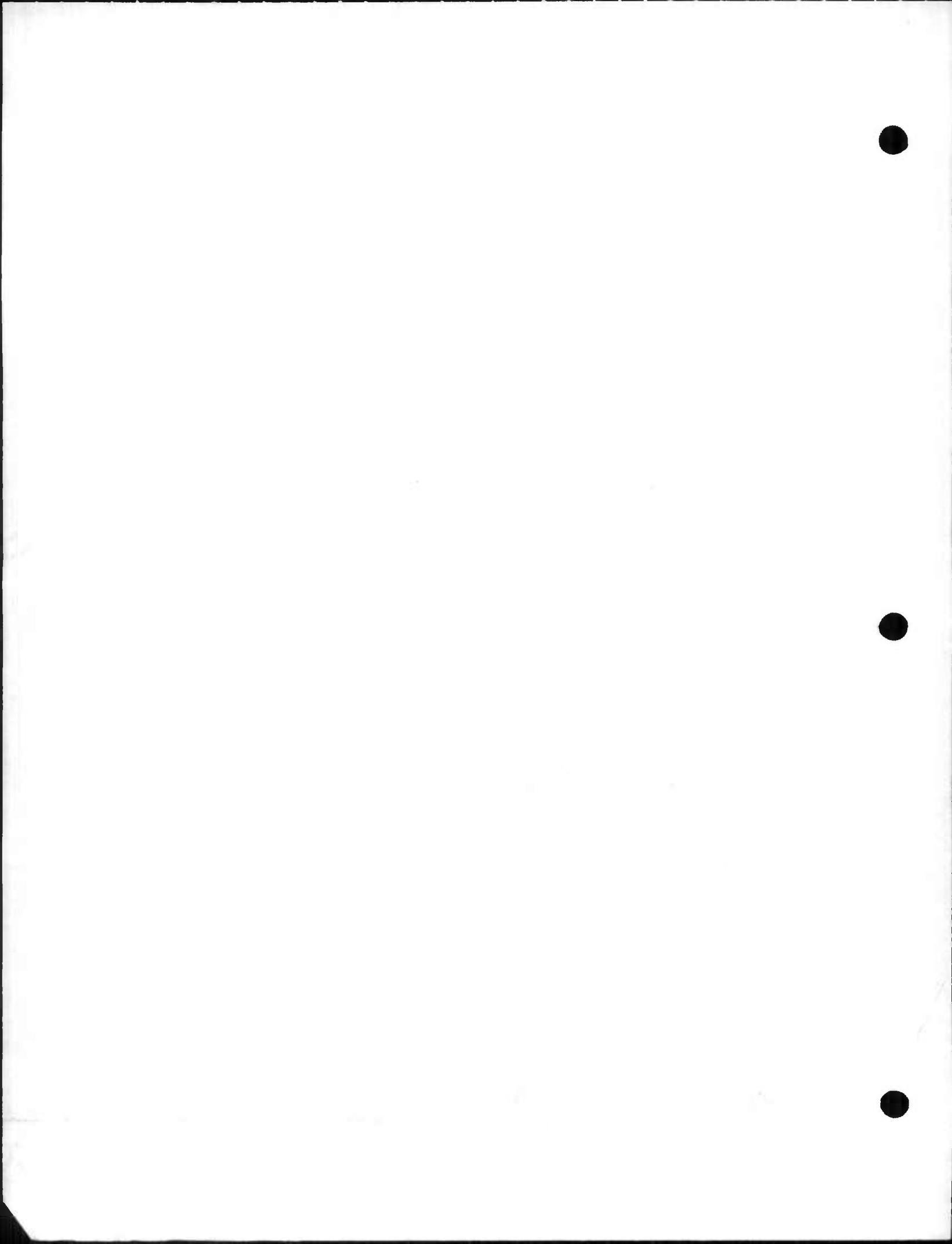
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1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH 11:40 PM			
Sarah E Holland		June 5, 1995											
4. SOCIAL SECURITY NUMBER 232-44-0445		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) APR 6, 1909			
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA								9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION FORESTVILLE								10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6463 PENNSYLVANIA AVE., #1ST FL		10f. ZIP CODE 20747								10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:								14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY PRIVATE HOME									
17. FATHER'S NAME (First, Middle, Last) WILLIAM PATTERSON		18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH UNK											
19a. INFORMANT'S NAME (Type/Print) VIRGINIA MORGAN (DAUGHTER)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6463 PA AVE #1ST FL, FORESTVILLE, MD. 20747											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) RESTLAWN CEMETERY		DATE 6/9		20c. LOCATION — City or Town, State WELCH, WEST VA.							
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>Alex S. Pope</i>		22. NAME AND ADDRESS OF FACILITY M859 ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → S. metastatic colon cancer to liver.												Approximate Interval Between Onset and Death 18mm	
DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>anemia, hypotension, ascites</i>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. LICENSE NUMBER DD1499								29d. DATE SIGNED (Month, Day, Year) ► June 6, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Lewis Dennis, MD Washington Adventist Hosp., Takoma Pk, Md													
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE <i>Jahn Dennis Hardell</i>											



AMENDED #4 6/6/95 EIM P.G.C.

95 19042

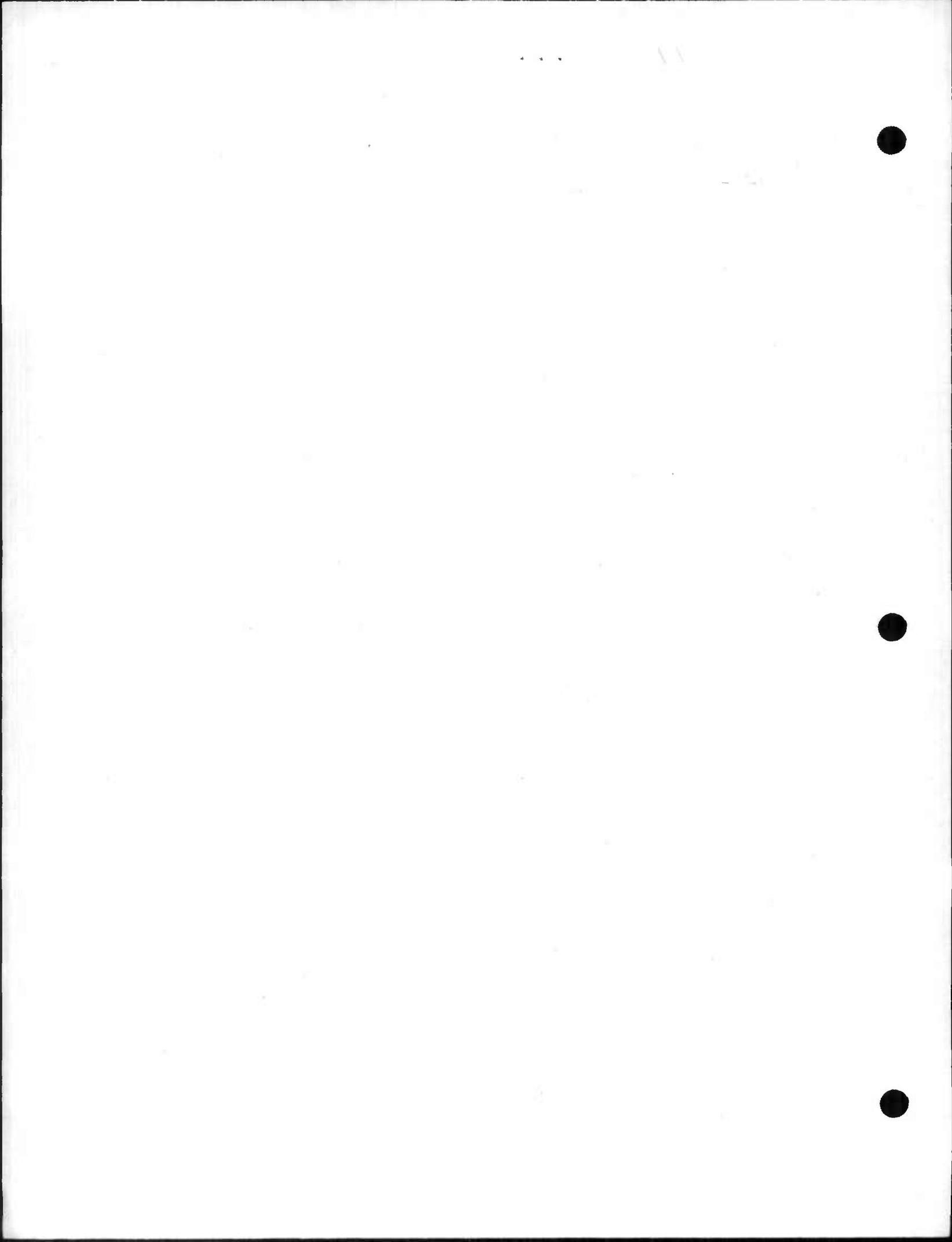
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Curtis Augustus Heflin								2. DATE OF DEATH MONTH DAY YEAR June 1, 1995	3. TIME OF DEATH 10:15A M		
4. SOCIAL SECURITY NUMBER 577-14-1855		5. SEX M	6. AGE (In yrs. last birthday) 78 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. 0 0 0 0	9. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL	10. CITY, TOWN OR LOCATION OF DEATH LANHAM	11. COUNTY OF DEATH PRINCE GEORGES	12. DATE OF BIRTH (Month, Day, Year) August 7, 1916	13. BIRTHPLACE (State or Foreign Country) Washington, DC	
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Prince Georges	10c. CITY, TOWN OR LOCATION Lanham			10d. INSIDE CITY LIMITS? 1 YES 2 NO						
10e. STREET AND NUMBER 6917 Cipriano Woods Court				10f. ZIP CODE 20706	10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO If yes, give war or dates WW II U.S. Navy			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: Caucasian			14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman			16b. KIND OF BUSINESS/INDUSTRY Air Products & Chemicals						
17. FATHER'S NAME (First, Middle, Last) William Curtis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Neitzey							
19a. INFORMANT'S NAME (Type/Print) William Curtis Heflin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 Point Mary, Dunkirk, MD 20754							
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery			DATE 6/5/95	20c. LOCATION — City or Town, State Cheltenham, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Rendon/Hale Lanham Funeral Home 9013 Annapolis Road, Lanham, MD 20706							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. ASPIRATION PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): CONGESTIVE HEART FAILURE b. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE c. ATRIAL FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 DAYS 6 years 20 yrs 6 years											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
ATRIAL FIBRILLATION							24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)							
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 7 Determined 4 Homicide				28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M 1 YES 2 NO	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURRED				
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
29b. SIGNATURE AND TITLE OF CERTIFIER V. SINGH				29c. LICENSE NUMBER D19897			29d. DATE SIGNED (Month, Day, Year) ► 6/29/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) V. SINGH 7209A Hanover Parkway Greenbelt Md 20770											
31. DATE FILED (Month, Day, Year) JUN 05 1995				32. REGISTRAR'S SIGNATURE John Davidor Rosell							

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH			
1. DECEASED'S NAME (First, Middle, Last)										05/30/95	4:45 PM		
Emanuel D. Harris		4. SOCIAL SECURITY NUMBER 579-38-4284		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
9a. FACILITY NAME (If not institution, give street and number) FT. WASHINGTON MEDICAL CENTER										7. DATE OF BIRTH (Month, Day, Year) APR 4, 1932			
9b. CITY, TOWN OR LOCATION OF DEATH FT. WASHINGTON										8. BIRTHPLACE (State or Foreign Country) WASH., D.C.			
9c. COUNTY OF DEATH PRINCE GEORGES													
RESIDENCE OF DECEASED													
10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION FT. WASHINGTON								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8102 KERBY PARKWAY CT.,										10f. ZIP CODE 20744		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951 1953		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2		16b. KIND OF BUSINESS/INDUSTRY TRAINING REP.		16c. LOCATION — City or Town, State D.C. GOVERNMENT							
17. FATHER'S NAME (First, Middle, Last) GAINNEY HARRIS										18. MOTHER'S NAME (First, Middle, Maiden Surname) CAROL WILSON			
19a. INFORMANT'S NAME (Type/Print) CYNTHIA H. HARRIS (WIFE)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6411 LIVINGSTON RD #401, OXON HILL, MD 20745									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY		20c. DATE		20c. LOCATION — City or Town, State 6/3 SUITLAND, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i>										22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOMES 5538 MARLBORO PIKE, FORESTVILLE, MD 20747			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):													
b. _____ DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Status post 1 week angio-plasty										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>		29c. LICENSE NUMBER D21230		29d. DATE SIGNED (Month, Day, Year) 05/30/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD 5009 Rayburn Ct. Camp Springs, MD 20748													
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE <i>John Marshall Randal</i>											

95 19044

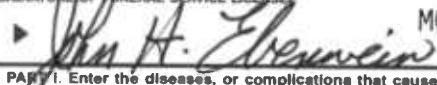
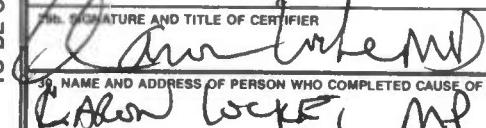
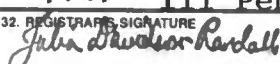
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

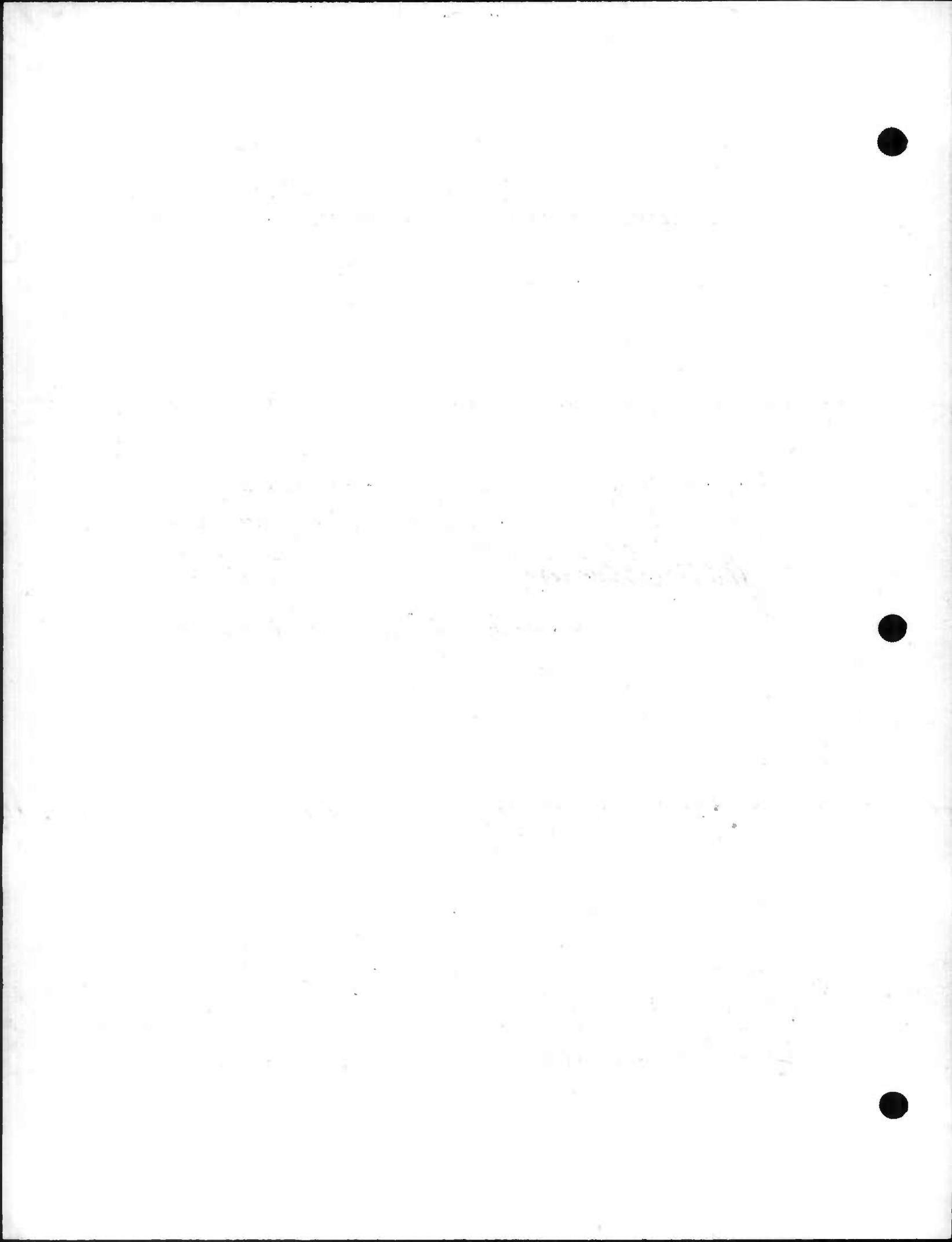
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH JUNE DAY 06 YEAR 1995										3. TIME OF DEATH 1:36 PM	
1. DECEDENT'S NAME (First, Middle, Last) AUBREY LEE HOLLEY SR												7. DATE OF BIRTH (Month, Day, Year) Feb 28, 1931	
4. SOCIAL SECURITY NUMBER 227-34-198		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0		HOURS 0		MIN. 0		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL												9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK	9c. COUNTY OF DEATH CALVERT
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Charles	10c. CITY, TOWN OR LOCATION Benedict										10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER PO Box 244						10f. ZIP CODE 20612				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter			16b. KIND OF BUSINESS/INDUSTRY Construction							
17. FATHER'S NAME (First, Middle, Last) Unknown						18. MOTHER'S NAME (First, Middle, Maiden Surname) Pearl Dixon Holley							
19a. INFORMANT'S NAME (Type/Print) Aubrey Lee Holley JR						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 244 Benedict, MD 20612							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens			DATE 6-13-95			20c. LOCATION — City or Town, State Waldorf, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00173						22. NAME AND ADDRESS OF FACILITY J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease													
DUE TO (OR AS A CONSEQUENCE OF):													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER only 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  Aubrey Lee Holley Jr.						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) JUNE 07, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. Alan Locke, MD						31. DATE FILED (Month, Day, Year) JUN 13 1995							
32. REGISTRAR'S SIGNATURE  John H. Eberwein													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

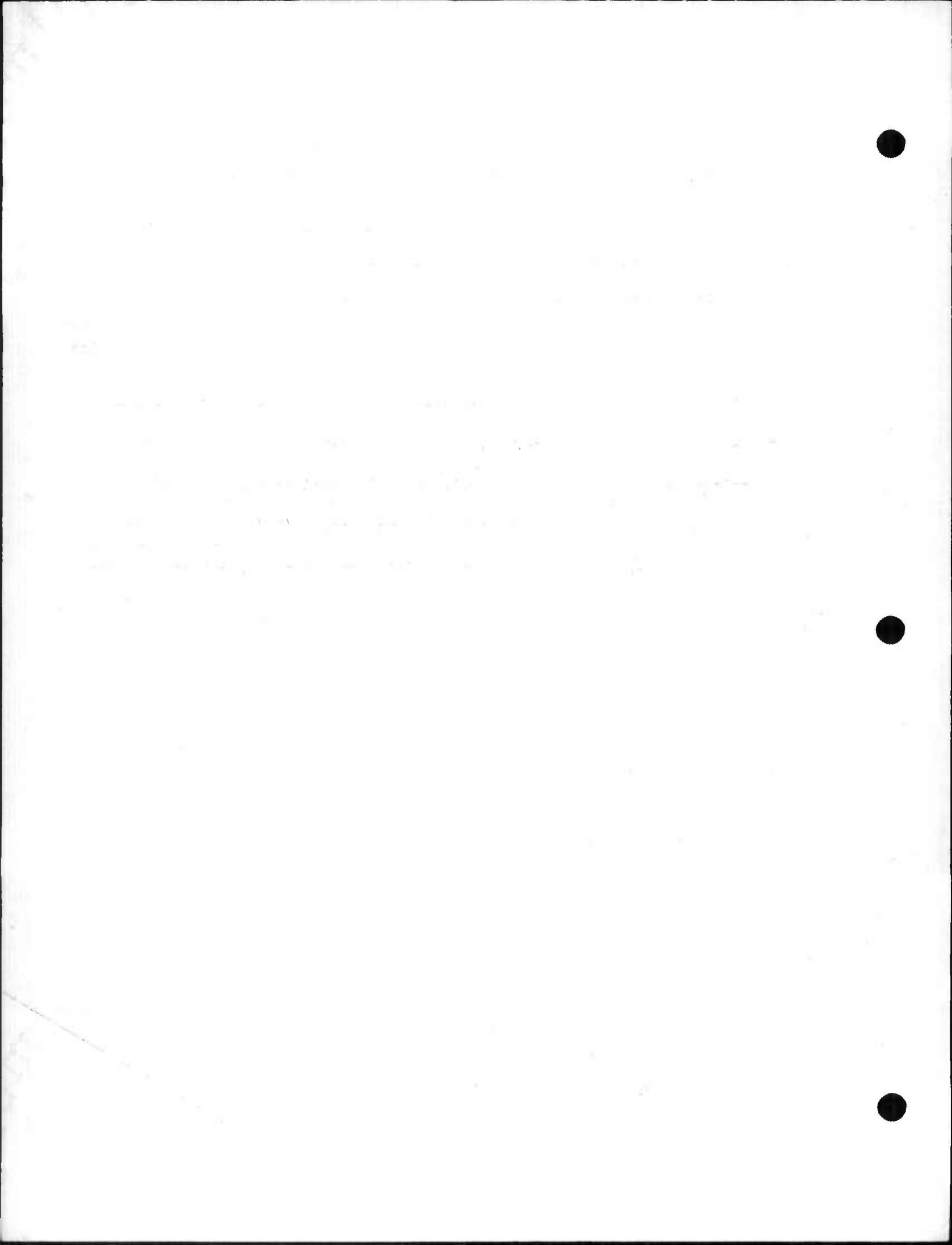
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH 23:05 M	
1. DECEDENT'S NAME (First, Middle, Last) FRANK WEBSTER HAWKINS										7. DATE OF BIRTH (Month, Day, Year) Feb. 14, 1924	8. BIRTHPLACE (State or Foreign Country) Maryland
4. SOCIAL SECURITY NUMBER 213-22-1136		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK	9c. COUNTY OF DEATH CALVERT
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Huntingtown						10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO	
10e. STREET AND NUMBER 3250 Solomons Island Road				10f. ZIP CODE 20639				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitor				16b. KIND OF BUSINESS/INDUSTRY Board of Education					
17. FATHER'S NAME (First, Middle, Last) Isaac Hawkins				18. MOTHER'S NAME (First, Middle, Maiden Surname) Viola Giles							
19a. INFORMANT'S NAME (Type/Print) Darlene Hawkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P. O. Box 352 Huntingtown, MD 20639							
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Patuxent UM Church Cem. 6/14/95				DATE 6/14/95		20c. LOCATION — City or Town, State Huntingtown, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Spencer E. Sewell</i>				22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Coronary Artery Disease</i>											
a. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF) <i>Hypercholesterolemia</i>											
b. <i>Hypercholesterolemia</i> DUE TO (OR AS A CONSEQUENCE OF):											
c. <i>Hypercholesterolemia</i> DUE TO (OR AS A CONSEQUENCE OF):											
d. <i>Hypercholesterolemia</i> DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Insulin dependent diabetes mellitus</i> <i>Hypertension, Cardiovascular Disease</i>										24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 X NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 X ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)									
27. MANNER OF DEATH 1 □ Natural 5 □ Pending investigation 2 □ Accident 3 □ Suicide 6 □ Could not be determined 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Mukesh Mathur</i>		29c. LICENSE NUMBER D-25435		29d. DATE SIGNED (Month, Day, Year) 6/14/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Janice Dawson-Robell</i>							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

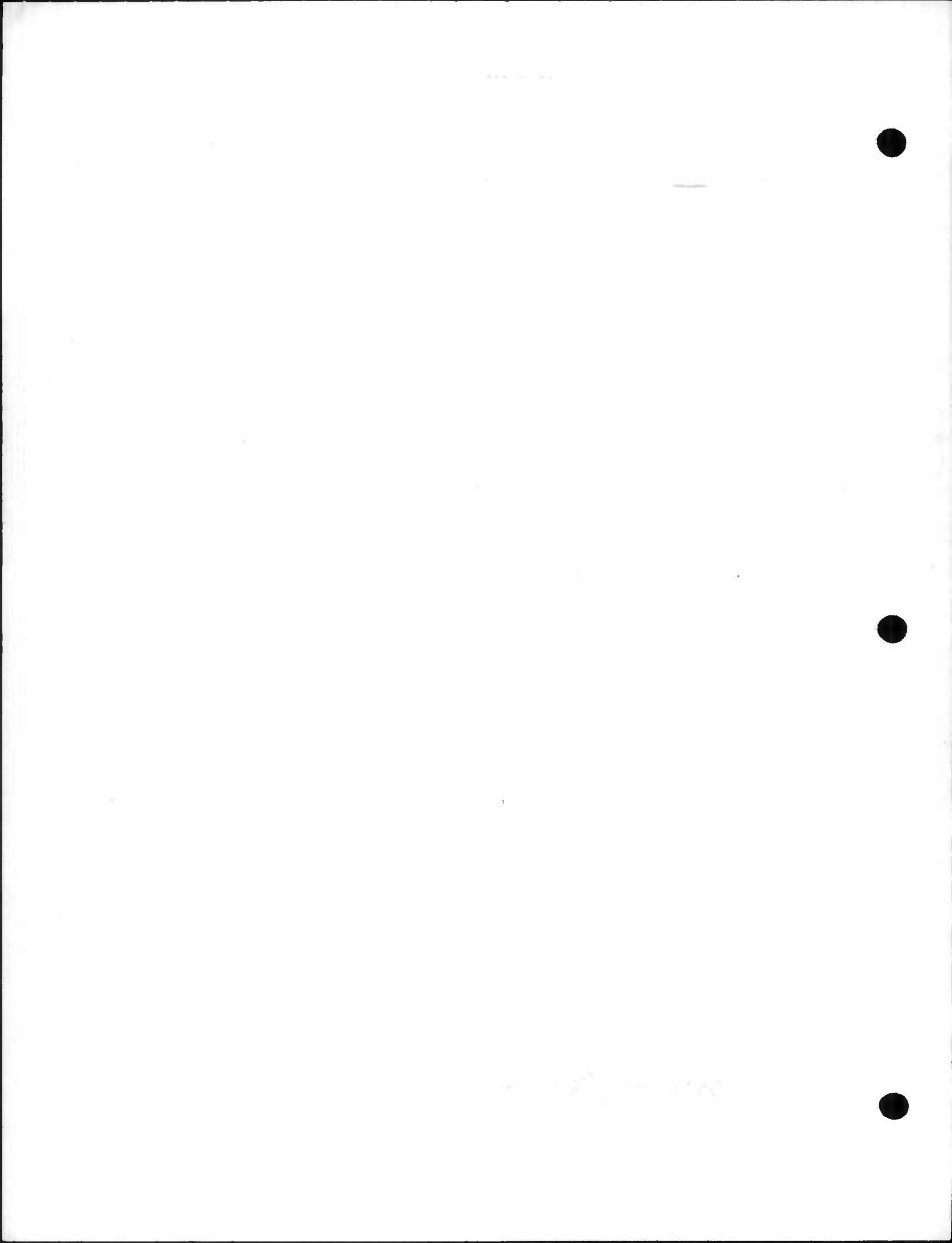
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <i>Cecil Clay Hayes</i>												2. DATE OF DEATH MONTH 6 DAY 10 YEAR 95	3. TIME OF DEATH 10:55 A.M.
4. SOCIAL SECURITY NUMBER 218-28-3570-3510		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 1, 1930		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) 296 Old Farmington Road						9b. CITY, TOWN OR LOCATION OF DEATH North East						9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION North East						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 296 Old Farmington Road						10f. ZIP CODE 21901				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Clerk			16b. KIND OF BUSINESS/INDUSTRY Retail							
17. FATHER'S NAME (First, Middle, Last) Jack Hayes						18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Lillian Brooks							
19a. INFORMANT'S NAME (Type/Print) Martha L. Brock						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 296 Old Farmington Road - North East, MD 21901							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bay View Cemetery				20c. LOCATION — City or Town, State DATE 16-13 1995 Bay View, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Hicks</i>						22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Canceroma of Bladder w extensive metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>metastasis</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>													
Approximate Interval Between Onset and Death 9 mo													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
26a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William F. Renzulli M.D.</i>		29c. LICENSE NUMBER D44102		29d. DATE SIGNED (Month, Day, Year) ► 6/10/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) William F. Renzulli, M.D. - 901 Warburton Road - Elkton, MD 21921													
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>John W. Renzulli</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, curation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

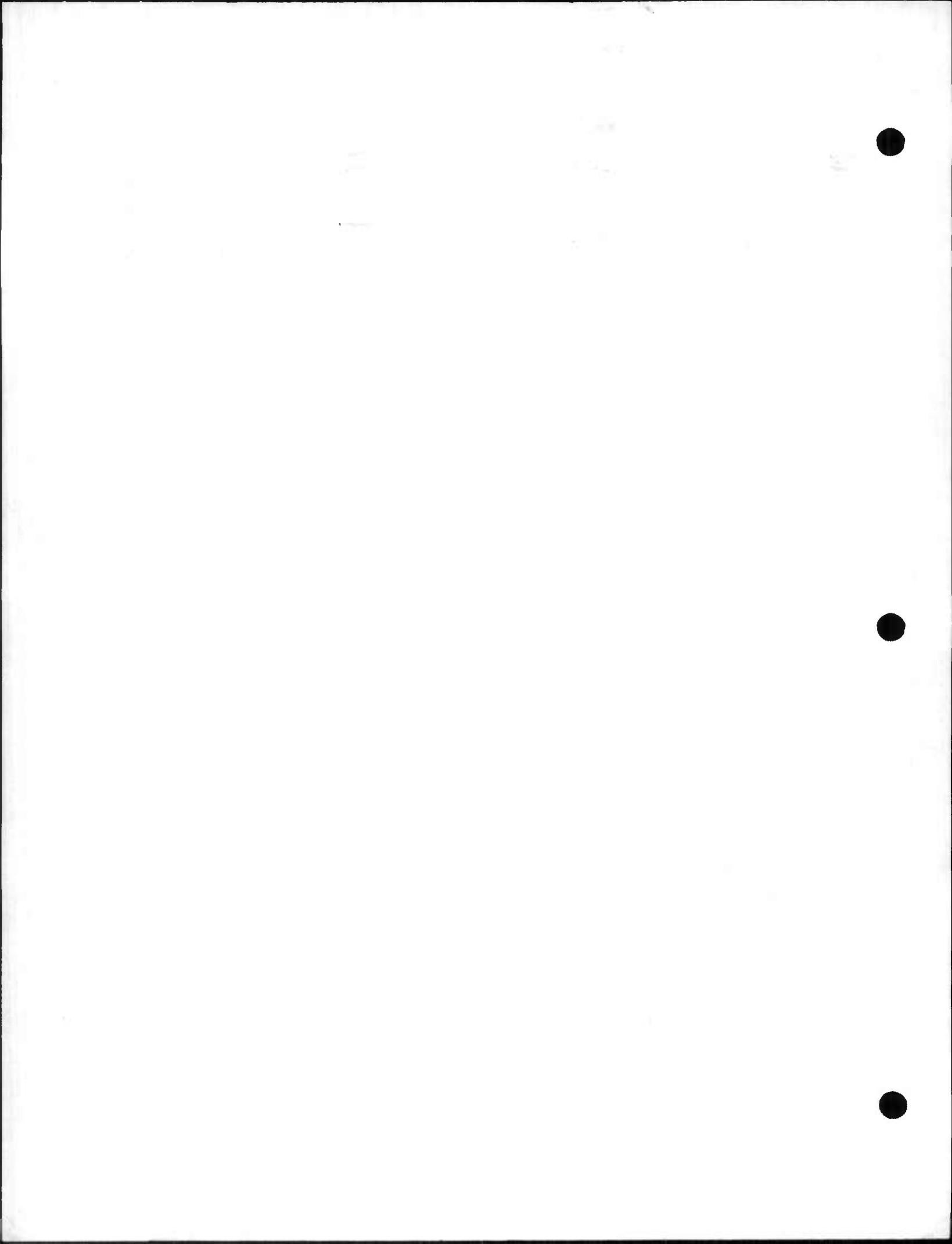
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19047

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH MONTH DAY YEAR
Violet Fannie Holmes						JUNE 7 95	1200 noon
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)	
218-40-4319		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	50 YRS.	MONTHS	DAYS	HOURS	MIN.
8a. FACILITY NAME (If not institution, give street and number)						8b. CITY, TOWN OR LOCATION OF DEATH	
Union Hospital of Cecil County						Elkton	
RESIDENCE OF DECEDENT							
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland	Cecil	Elkton					
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
110 Hollingsworth Manor				21921		United States	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Homemaker			Her own Home		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Edward Collins				Ethel Osborne			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Gilbert P. Holmes				110 Hollingsworth Manor, Elkton, MD 21921			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE	20c. LOCATION — City or Town, State
				Hart's Cemetery		6/9	Elk Neck, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Robert T. Crow				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 South Main Street, North East, MD 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Massive Pulmonary Embolus DUE TO (OR AS A CONSEQUENCE OF): Deep vein thrombosis DUE TO (OR AS A CONSEQUENCE OF): R Hemispheric CVA DUE TO (OR AS A CONSEQUENCE OF): Carotid artery disease							
Approximate Interval Between Onset and Death 12 hrs 2-3 days 1 week years							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD Hypertension ASCAD.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER D45155			
29b. SIGNATURE AND TITLE OF CERTIFIER John Mulvey M.D.				29d. DATE SIGNED (Month, Day, Year) ► 6/7/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Mulvey M.D. 118 North St Suite 2A Elkton, Md							
31. DATE FILED (Month, Day, Year) JUN 08 1995				32. REGISTRAR'S SIGNATURE Julie Shadron-Karrell			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

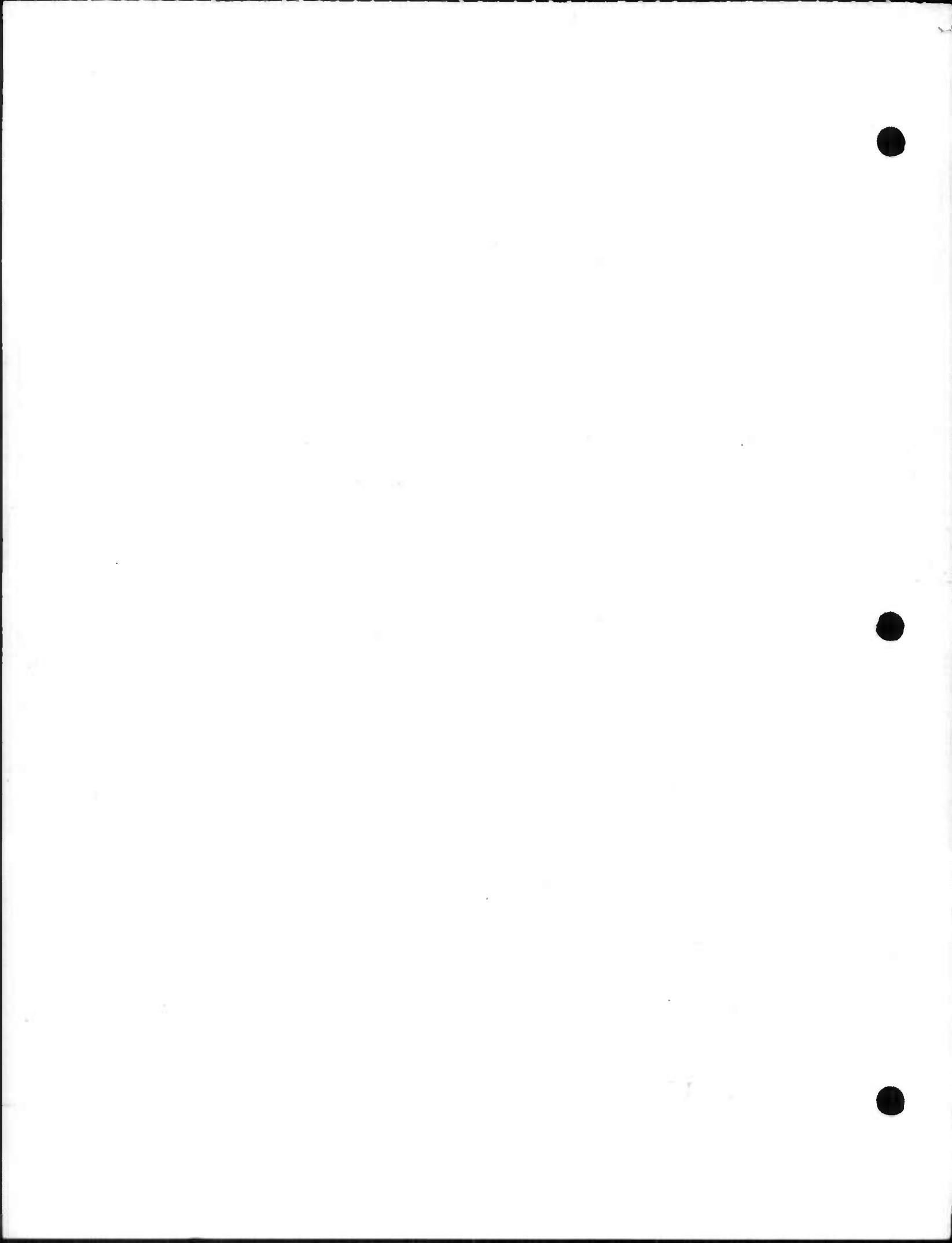
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Francis Leo Hoffman										2. DATE OF DEATH MONTH June DAY 9 YEAR 1995	3. TIME OF DEATH 4:34 A.M.
4. SOCIAL SECURITY NUMBER 220-10-5146		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Nov. 1, 1915	8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick				
RESIDENCE OF DECEDENT										10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick							
10e. STREET AND NUMBER 6012 Quartet Lane				10f. ZIP CODE 21702			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES July 19, 1943-Jan. 6, 1946		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Maintenance Technician		16b. KIND OF BUSINESS/INDUSTRY US Government							
17. FATHER'S NAME (First, Middle, Last) John Joseph HOFFMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Fannie MYERS							
19a. INFORMANT'S NAME (Type/Print) Mrs. Marjorie V. Hoffman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6012 Quartet Lane, Frederick, Maryland 21702							
20a. METHOD OF DISPOSITION 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 8 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg Crematory		DATE June 10, 1995			20c. LOCATION — City or Town, State Smithsburg, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Richard E. Hay				22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
23. PART I. Enter the disease(s), or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 2 DAYS	
IMMEDIATE CAUSE (Final disease or condition → resulting in death)											
a. <i>Lower Gastrointestinal Bleeding</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Divericulitis</i>											
b. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Small cell lung cancer</i>										24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)							
27. MANNER OF DEATH 1 □ Natural 5 □ Pending Investigation 2 □ Accidental 3 □ Suicide 8 □ Could not be determined 4 □ Homicide				28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURED				
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Allen J. Gilson MD</i>				29c. LICENSE NUMBER D26516			29d. DATE SIGNED (Month, Day, Year) JUNE 9 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Allen J. Gilson MD</i>				32. REGISTRAR'S SIGNATURE <i>John Dawson Parlett</i>							
31. DATE FILED (Month, Day, Year) JUN 12 1995											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

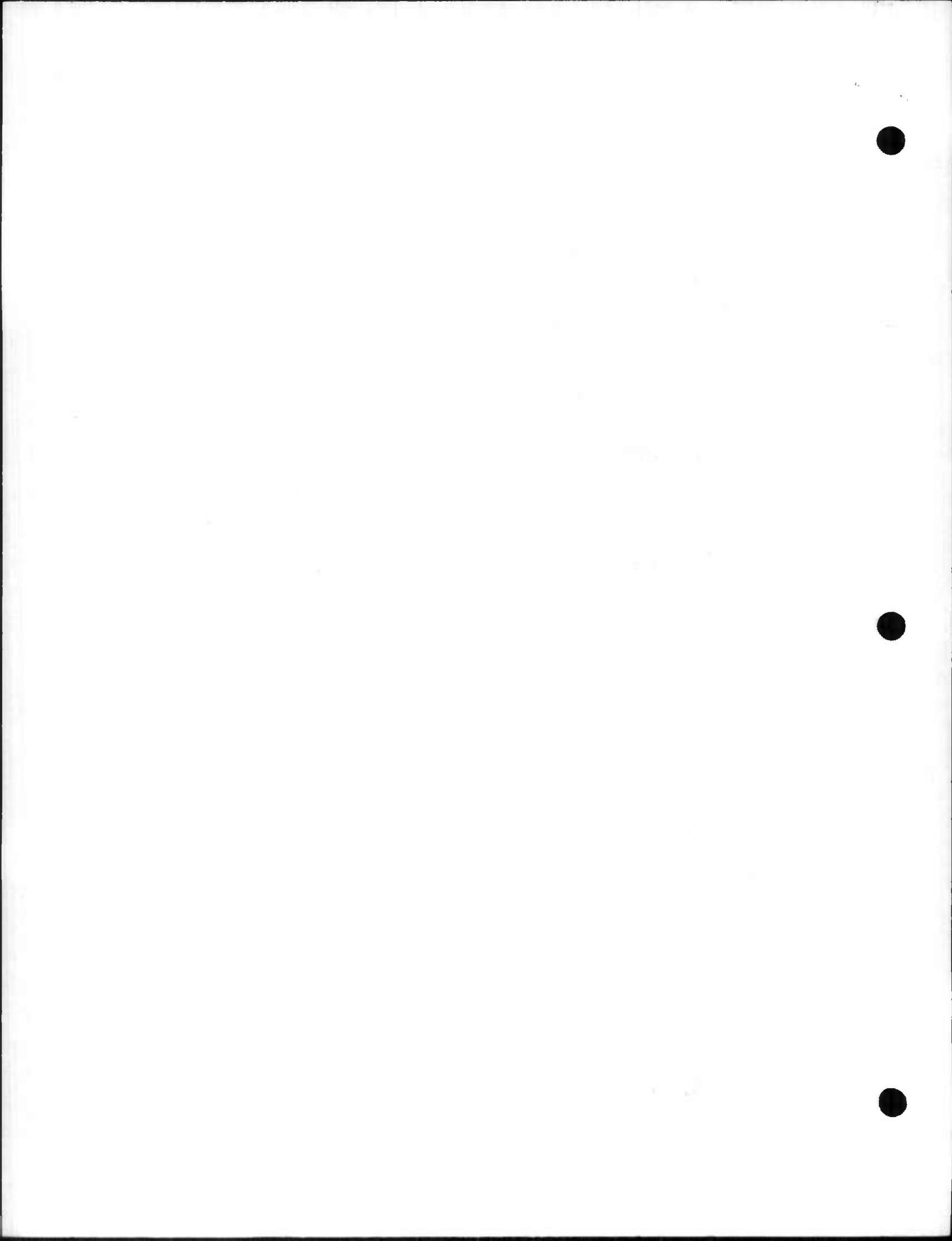
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)		JOSEPH HERBST								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH HRS. MIN.		
4. SOCIAL SECURITY NUMBER 219-14-7533		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov 7, 1922		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not Institution, give street and number) Carroll County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Westminster								9c. COUNTY OF DEATH Carroll			
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Westminster								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 550 Lacosta Circle				10f. ZIP CODE 21157				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1/21/44-5/46		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Installer		16b. KIND OF BUSINESS/INDUSTRY C&P Telephone Co.									
17. FATHER'S NAME (First, Middle, Last) Theophilus Herbst, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Katherine Brandenburg									
19a. INFORMANT'S NAME (Type/Print) Darrin Herbst				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3425 Viewridge Ct, Manchester, MD 21102									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Evergreen Mem Gardens		DATE 6/15		20c. LOCATION — City or Town, State Finksburg, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Steven W. Elvin</i>		22. NAME AND ADDRESS OF FACILITY Eline Funeral Home 934 S Main St, Hampstead, MD 21074											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. <i>Cardiovascular accident</i> DUE TO (OR AS A CONSEQUENCE OF): 1 hour													
b. <i>Atherosclerotic vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF): 5 years													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dan H. Schreyfeder, MD</i>		29c. LICENSE NUMBER D28221		29d. DATE SIGNED (Month, Day, Year) <i>June 12, 1995</i>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dan H. Schreyfeder, MD</i>		31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>Julia Schreyfeder</i>		WESTMINSTER 21157							



95 19050

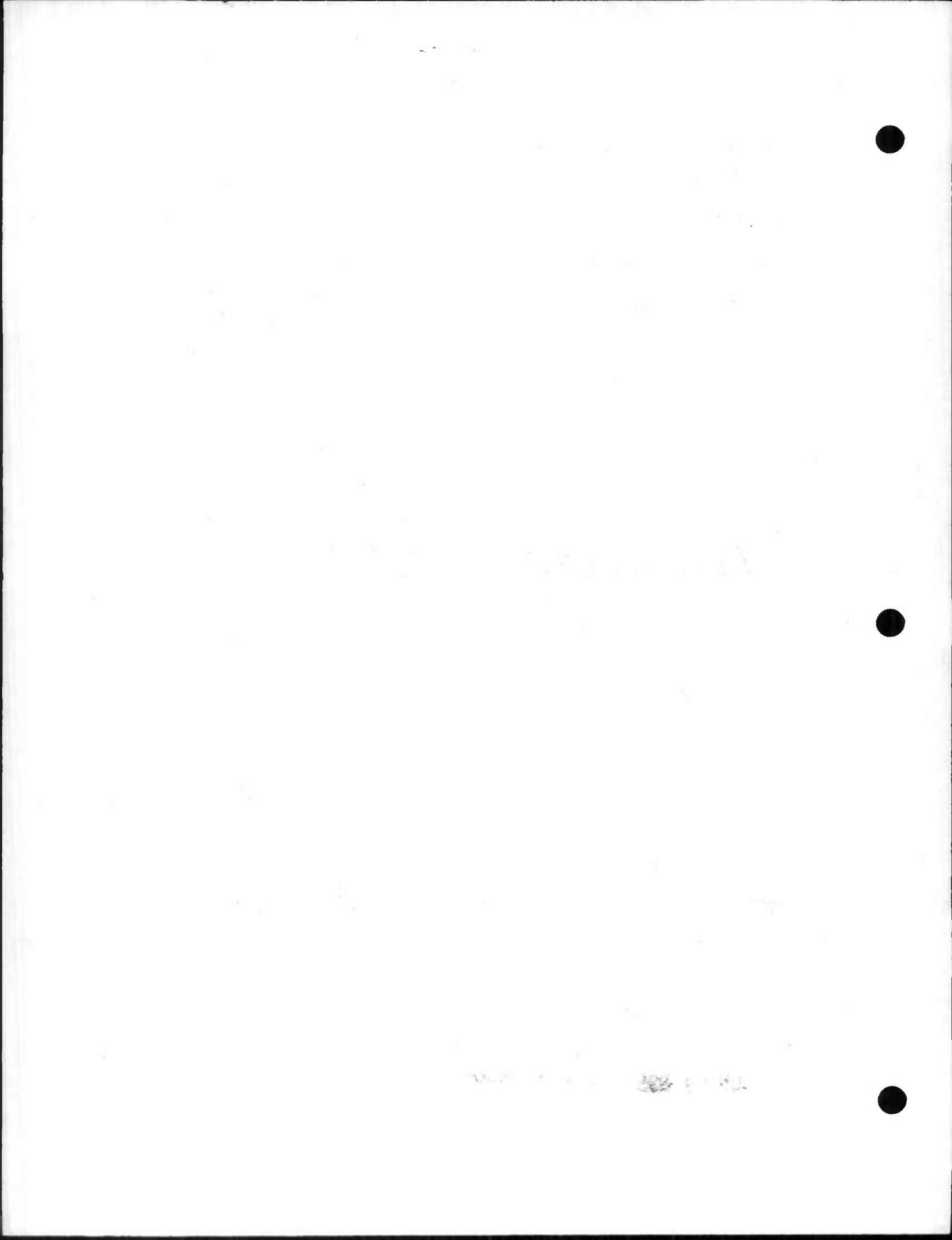
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH JUNE DAY 17 YEAR 1995	3. TIME OF DEATH 10:58 A M				
DORIS E. LIZABETH HOFMANN										7. DATE OF BIRTH (Month, Day, Year) Oct. 23, 1958	8. BIRTHPLACE (State or Foreign Country) Germany				
4. SOCIAL SECURITY NUMBER 213-80-0455		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.								
9a. FACILITY NAME (If not institution, give street and number) GARRETT COUNTY MEMORIAL RESIDENCE OF DECEDENT										9b. CITY, TOWN OR LOCATION OF DEATH OAKLAND	9c. COUNTY OF DEATH GARRETT				
10a. STATE Maryland	10b. COUNTY Garrett	10c. CITY, TOWN OR LOCATION Oakland								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 101 W. Pennington Street										10f. ZIP CODE 21550	10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 7 Clinical Social Worker				16b. KIND OF BUSINESS/INDUSTRY Garrett Co. Health Dept.									
17. FATHER'S NAME (First, Middle, Last) Alfons Hofmann										18. MOTHER'S NAME (First, Middle, Maiden Surname) Lieselotte Delhougne					
19a. INFORMANT'S NAME (Type/Print) Lisa Takala										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 403 South Lake Court Stevensville, MD 21666					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Omega Crematory				DATE	20c. LOCATION — City or Town, State Morgantown, WV								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Franklin H. Custer</i>										22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second Street Oakland, MD 21550					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Head and Neck Injuries DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6/17/95	26b. TIME OF INJURY 1003 AM	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED <i>Subject struck me on my neck while I was driving my car</i>
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Oakland 9 Glendale Road in Maryland					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. King, M.D.</i>										29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) ►JUNE 18, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Theodore M. King, M.D.</i>										111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) JUN 19 1995										REGISTRAR'S SIGNATURE <i>Jeanne Parker</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19051

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH				
Dannie R. Ingram						June 1, 1995	8:15 A. M				
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)		
225-54-7209		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	52 YRS.	MONTHS	DAYS	HOURS	MIN.	Jan. 24, 1943	Virginia		
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH			
7908 Prentice Court						Fort Washington		Prince George's			
RESIDENCE OF DECEDENT											
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
Maryland	Prince George's		Fort Washington								
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
7908 Prentice Court						20744		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Viet Nam				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 12		Depot Clerk				Metro					
17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NAME (First, Middle, Maiden Surname)					
Shields Ingram						Grace Banks					
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Clara P. Ingram						7908 Prentice Ct. Ft. Washington, Md. 20744					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE	20c. LOCATION — City or Town, State		
						Maryland Veterans Cemetery		6/5/95	Cheltenham, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →						s. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):					
						b. Coronary Artery Insufficiency DUE TO (OR AS A CONSEQUENCE OF):					
						c. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):					
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
						D 21230		► June 4, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, Md. 20748											
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 									

2 2 2

John R. Lewis
Montgomery, ALA 36104

95 19052

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

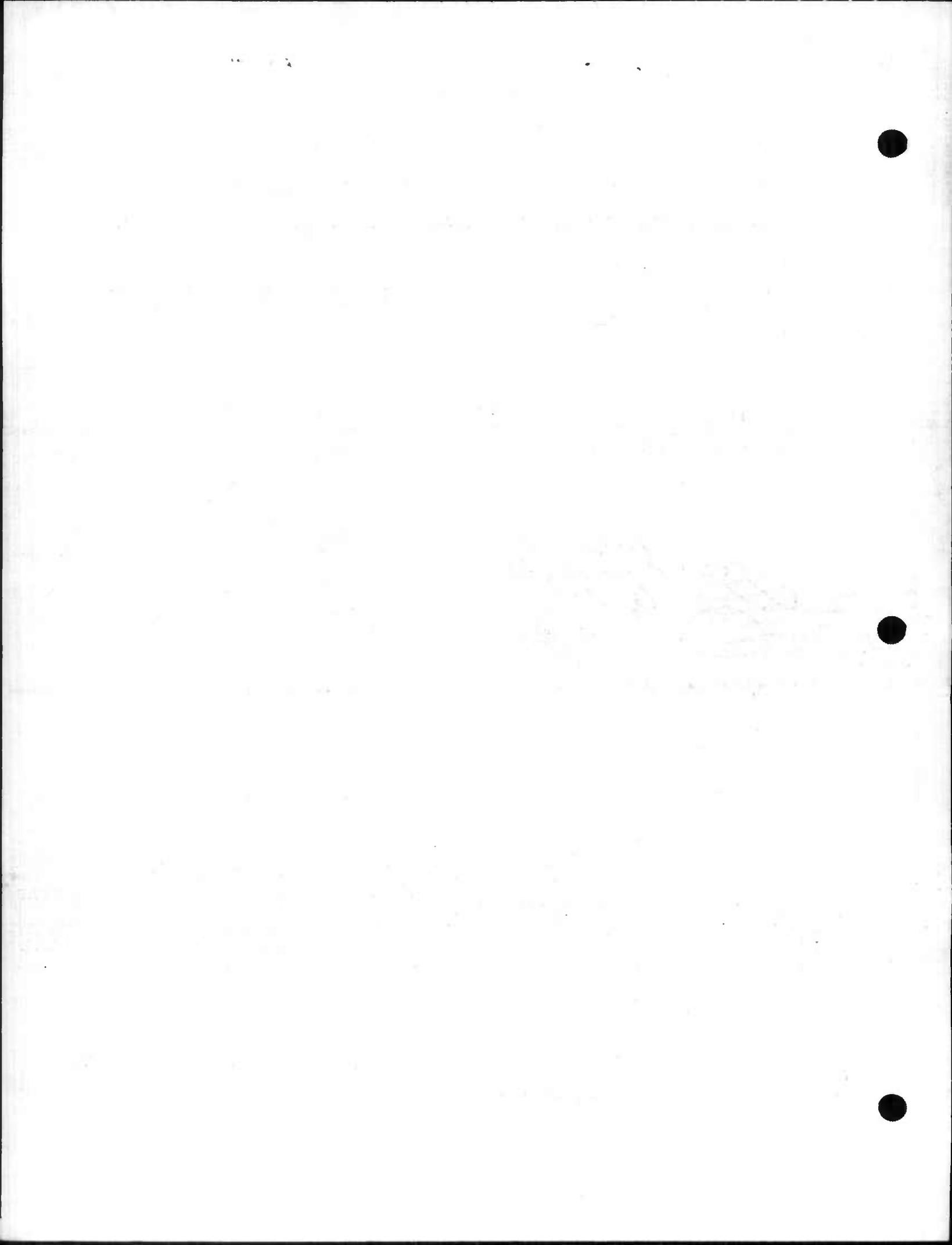
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
CHRISTOPHER DAVID JONES												MAY 5, 1995	11:10 A.M.		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)					
213-08-8100		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	20 YRS.	MONTHS	DAYS	HOURS	MIN.	DEC. 2, 1974		MARYLAND					
9a. FACILITY NAME (If not institution, give street and number)												9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
PENINSULA REGIONAL MEDICAL CENTER SALISBURY												WICOMICO			
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?							
MARYLAND		WICOMICO		SALISBURY				<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?							
300 BROOKDALE DRIVE						21801		USA							
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced															
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY									
Elementary/Secondary (0-12) 12		College (1-4 or 5+) TRUCK DRIVER				SNACK FOOD									
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)									
JOHN HORACE JONES, JR.						MARY DONOHUE									
19e. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
JOHN H. JONES, JR.						6799 COLEMAN AVENUE, SALISBURY, MD 21801									
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		WICOMICO MEMORIAL PARK				5/9		SALISBURY, MARYLAND							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald G. Beller</i>						22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, 1212 OLD OCEAN CITY RD P. O. BOX 3171, SALISBURY, MD 21802									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF):															
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)				27. MANNER OF DEATH									
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				28a. DATE OF INJURY (Month, Day, Year) 5/5/1995									
						28b. TIME OF INJURY 10:20A		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED DRIVER OF TRUCK THAT REAR ENDED A SECOND TRUCK					
						28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		ROADWAY		28f. LOCATION (Street and Number or Rural Route Number) MD ROUTE #12 AT FURNACE BRANCH ROAD SNOW HILL, MD					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) ► JUNE 7, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
DONALD G. WRIGHT M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Julie Stewson-Randall</i>				DHMH-16 Rev 1/89									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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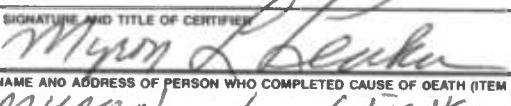
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

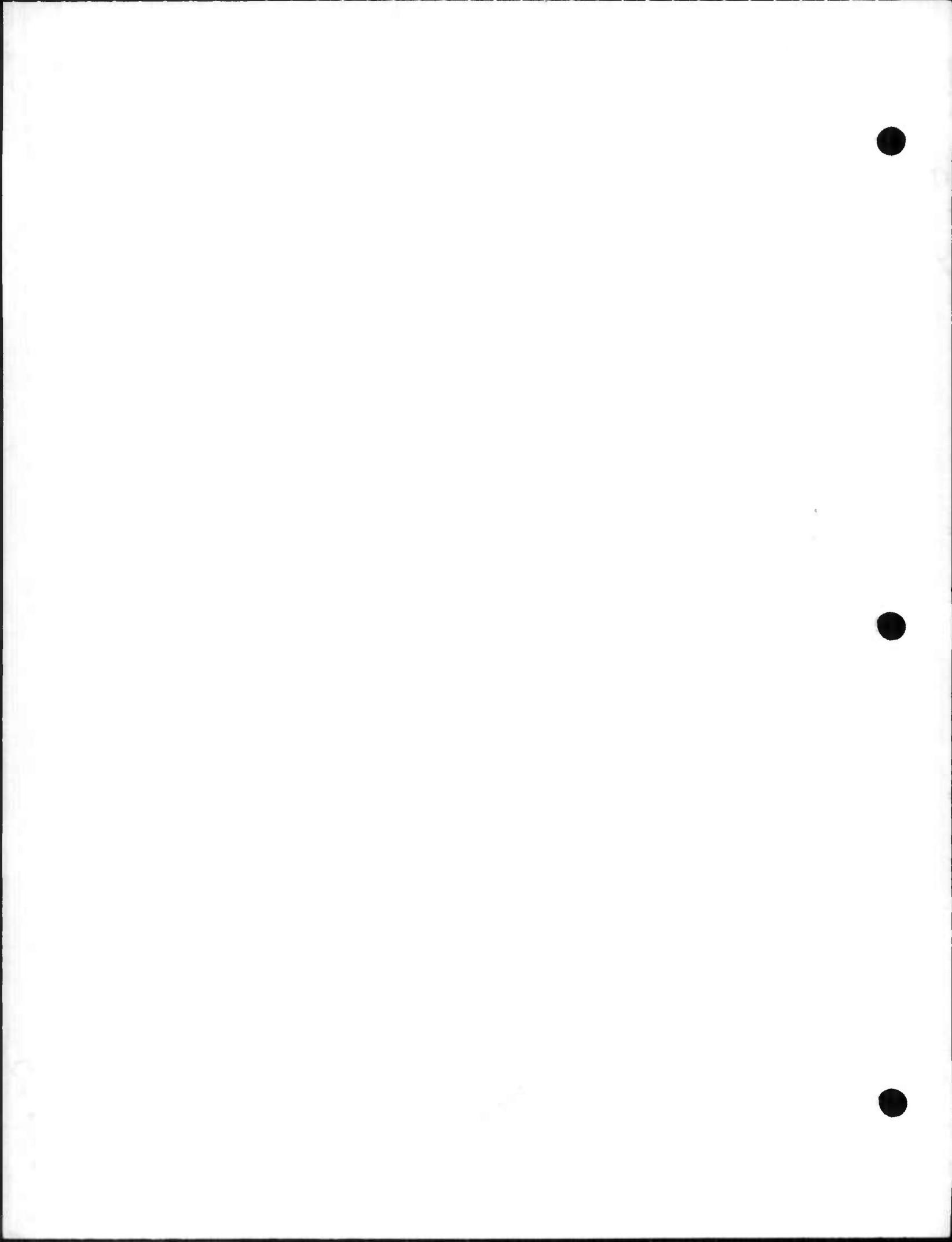
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19053

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH June 2 DAY 1995 YEAR 9:05 M	3. TIME OF DEATH
Pearl M. Jones					
4. SOCIAL SECURITY NUMBER 579-24-5505		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS HOURS DAYS	IF UNDER 24 HRS. MIN.
9a. FACILITY NAME (If not institution, give street and number) Presidential Woods Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Adelphia	
9c. COUNTY OF DEATH				PG	
RESIDENCE OF DECEDENT					
10a. STATE DC	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Washington			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
10e. STREET AND NUMBER 534 Hamilton St NE			10f. ZIP CODE 20011	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIN OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) James Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Ward	
19a. INFORMANT'S NAME (Type/Print) Consuello T. Jackson			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10a, b, c, d, e & f		
20a. METHOD OF DISPOSITION X <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park		DATE 6/8/95	20c. LOCATION — City or Town, State Landover, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY John T. Rhines Co., Inc. 3030 12th St NE, DC 20017		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b.  DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 5 yr.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. LICENSE NUMBER 006674		29d. DATE SIGNED (Month, Day, Year) ► 2309 JUN 09 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Myron L. Lenker MD 2309 HORSEFIELD RD WHEATON MD					
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE Julia A. Wilson-Karbach			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**TO BE COMPLETED BY FUNERAL DIRECTOR**

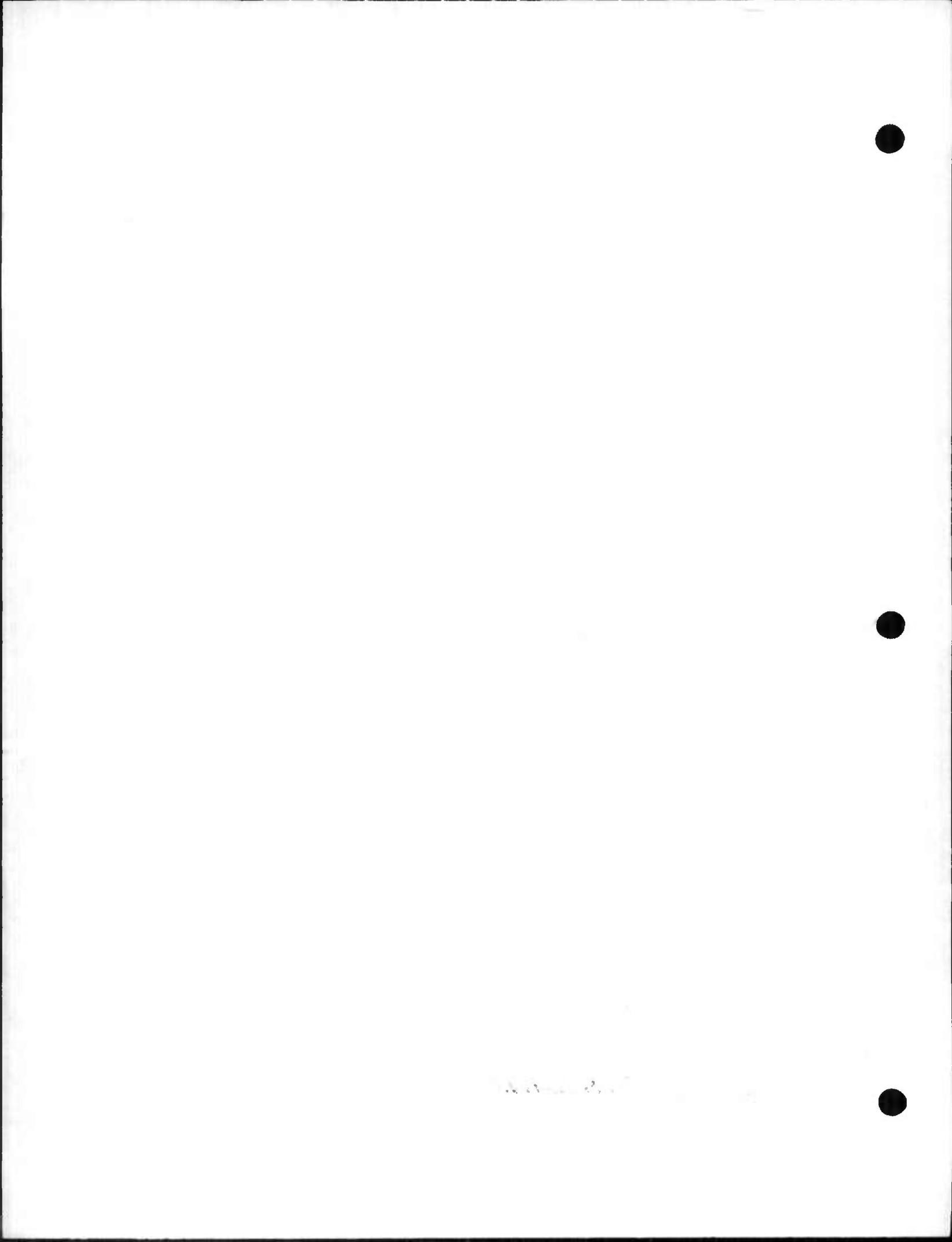
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19054

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 3:00 p.m. M	
<i>Robert E. Jones</i>		May 18, 1995			
4. SOCIAL SECURITY NUMBER 578-84-7526		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F 37 YRS.		6. AGE (In yrs. last birthday) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Olney, Maryland		9c. COUNTY OF DEATH Montgomery Co.	
10a. STATE MD.		10b. COUNTY Montgomery Co.		10c. CITY, TOWN OR LOCATION Silver Spring, MD.	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 1312 Elm Grove Circle, Silver Spr. Md.		10f. ZIP CODE 20905		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unemployed		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Robert E. Jones		18. MOTHER'S NAME (First, Middle, Maiden Surname) Arvetta Pugh			
19a. INFORMANT'S NAME (Type/Print) Pearl Wilson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1312 Elm Grove Circle, Silver Spring, MD. 20905			
20a. METHOD OF DISPOSITION Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Cemetery May 24, 1995		DATE	20c. LOCATION — City or Town, State Landover, MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ralph Williams</i>		22. NAME AND ADDRESS OF FACILITY Ralph Williams Funeral Service 517 11th St., SE, Wash., DC.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ovarian Cancer</i></p> <p>DUE TO (OR AS A CONSEQUENCE OF): <i>Cancer</i></p> <p>Approximate Interval Between Onset and Death: <i>One year</i></p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): _____</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): _____</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF): _____</p>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1312 Elm Grove Circle, Silver Spring, MD.			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 033086		29d. DATE SIGNED (Month, Day, Year) May 19, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Veronica M. Miller, RN, LPN, BSN, Prince Philip Primary, MD					
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE <i>Julie Shuster-Lindner</i>			

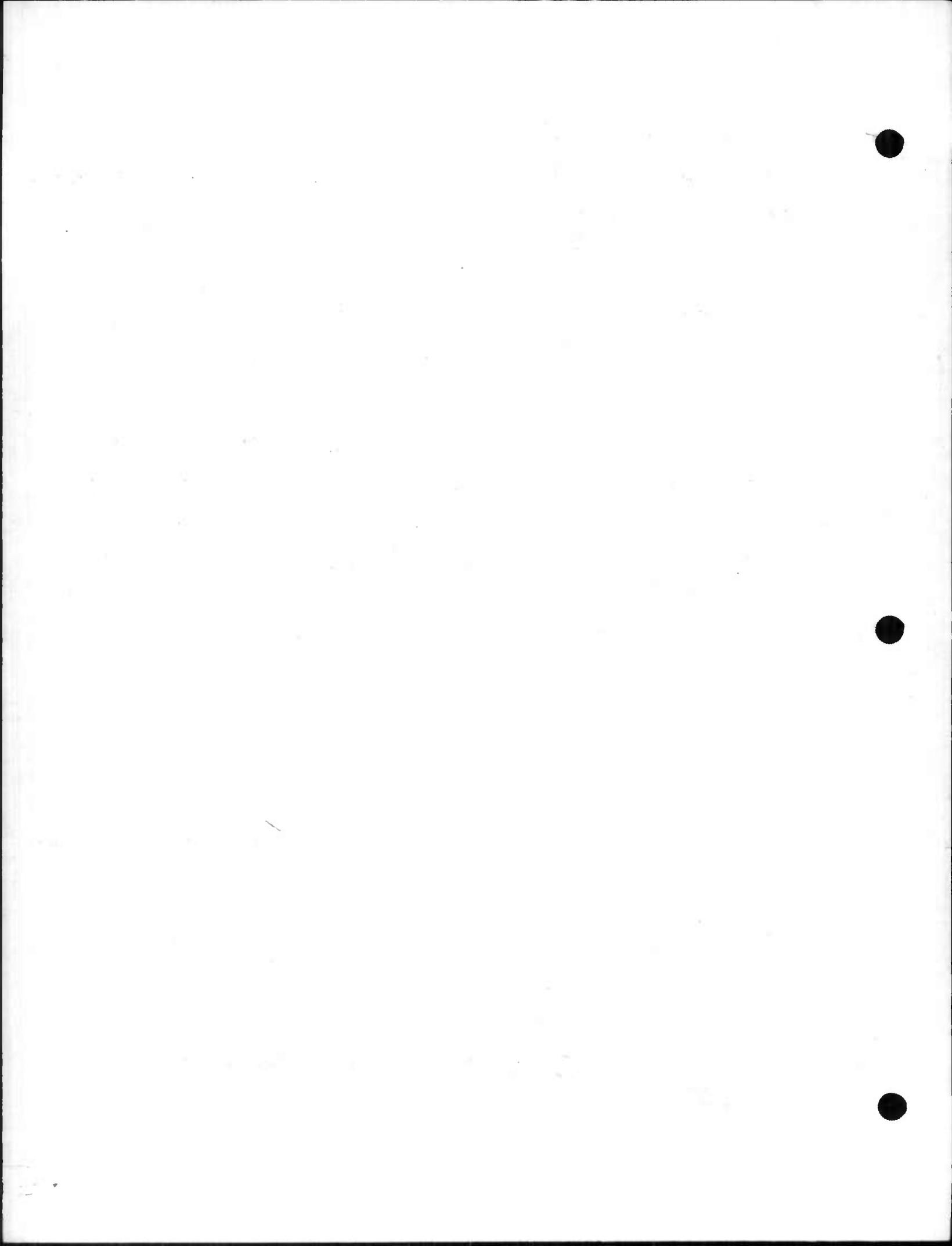


95 19055

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VINCENT A. JACKSON												2. DATE OF DEATH MONTH JUNE DAY 02.95 YEAR 1995	3. TIME OF DEATH 1:22 A M
4. SOCIAL SECURITY NUMBER 216 86 7204			5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 27 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	7. DATE OF BIRTH (Month Day Year) March 4, 1968	8. BIRTHPLACE (State or Foreign Country) Washington D.C.			
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY				9c. COUNTY OF DEATH PRINCE GEORGES					
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Prince George	10c. CITY, TOWN OR LOCATION Landover								10d. INSIDE CITY LIMITS? X YES 2 NO			
10e. STREET AND NUMBER 6341 Landover Road #104				10f. ZIP CODE 20785				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 □ NO IF YES, GIVE WAR OR DATES no			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 □ NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Airline Maintenance			16b. KIND OF BUSINESS/INDUSTRY Private							
17. FATHER'S NAME (First, Middle, Last) Ronald V. Jackson						18. MOTHER'S NAME (First, Middle, Maiden Surname) Verdice Reddick							
19a. INFORMANT'S NAME (Type/Print) Jacqueline Jackson						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12018 Hallandale Terrace Mitchellville, Md.							
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park			DATE 6/8/95			20c. LOCATION — City or Town, State Landover, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Sher I. Stewart, III													
22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Road, N.E., Washington, D.C.													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Gun shot wounds of head and neck DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____													
Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 □ NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 □ NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 X Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)										
27. MANNER OF DEATH 1 □ Natural 5 □ Pending investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			28a. DATE OF INJURY (Month, Day, Year) 6-2-95		28b. TIME OF INJURY Unknown		28c. INJURY AT WORK? 1 □ YES 2 □ NO		28d. DESCRIBE HOW INJURY OCCURRED Subject shot				
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4233 1st SE Washington D.C.										
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER David R. Fowler										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201			29c. LICENSE NUMBER O.C.M.E			29d. DATE SIGNED (Month, Day, Year) ► JUNE 2, 1995							
31. DATE FILED (Month, Day, Year) JUN 08 1995			John A. Schaeffer, M.D., F.A.C.P.										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.								
1. DECEDENT'S NAME (First, Middle, Last) ALVIN JACKSON										2. DATE OF DEATH MONTH DAY YEAR MAY 25 1995	3. TIME OF DEATH 2:45 PM							
4. SOCIAL SECURITY NUMBER 229-52-7184		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 9/16/41		8. BIRTHPLACE (State or Foreign Country) North Hampton	9. COUNTY OF DEATH PG							
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park	9c. COUNTY OF DEATH PG							
RESIDENCE OF DECEDENT																		
10a. STATE NA	10b. COUNTY NA	10c. CITY, TOWN OR LOCATION Washington, DC								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
10e. STREET AND NUMBER #13 Foster Street, S.E.					10f. ZIP CODE 20032					10g. CITIZEN OF WHAT COUNTRY? USA								
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 10 Nov. 1965			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Specify: BLACK				14. RACE — American Indian, Black, White, etc.									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)					16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Payrool Tech					16b. KIND OF BUSINESS/INDUSTRY HEW								
17. FATHER'S NAME (First, Middle, Last) Willie J. Jackson										18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilhimenia Bradshaw								
19a. INFORMANT'S NAME (Type/Print) Wilhimena Jackson/mother					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 502 Mt. Vale Ave. Richmond, Va. 23222													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Quantico National Cemetery					DATE 5/31/95	20c. LOCATION — City or Town, State Quantico, Va.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Robert G. Mason Funeral Home, Inc. 1661 Good Hope Rd., SE Wash., DC 20020								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acquired immunodeficiency syndrome</i>										Approximate Interval Between Onset and Death <i>undm</i>								
b. <i>DUE TO (OR AS A CONSEQUENCE OF):</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST																		
c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>																		
d. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>																		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Other medical problems besides AIDS</i>										34a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	34b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DGA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <table border="0"><tr><td><input type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td></td></tr><tr><td><input type="checkbox"/> Suicide</td><td><input type="checkbox"/> Could not be determined</td></tr><tr><td><input type="checkbox"/> Homicide</td><td></td></tr></table>					<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																	
<input type="checkbox"/> Accident																		
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																	
<input type="checkbox"/> Homicide																		
					28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 1 <input type="checkbox"/> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER BO1489					29d. DATE SIGNED (Month, Day, Year) May 2, 1995								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. LEWIS DENNIS 6201 Greenbelt Rd. College St. 20940																		
31. DATE FILED (Month, Day, Year) JUN 07 1995					32. REGISTRAR'S SIGNATURE 					DHMH-16 Rev 1/89								

LONG BOUND

137

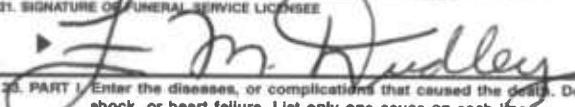
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

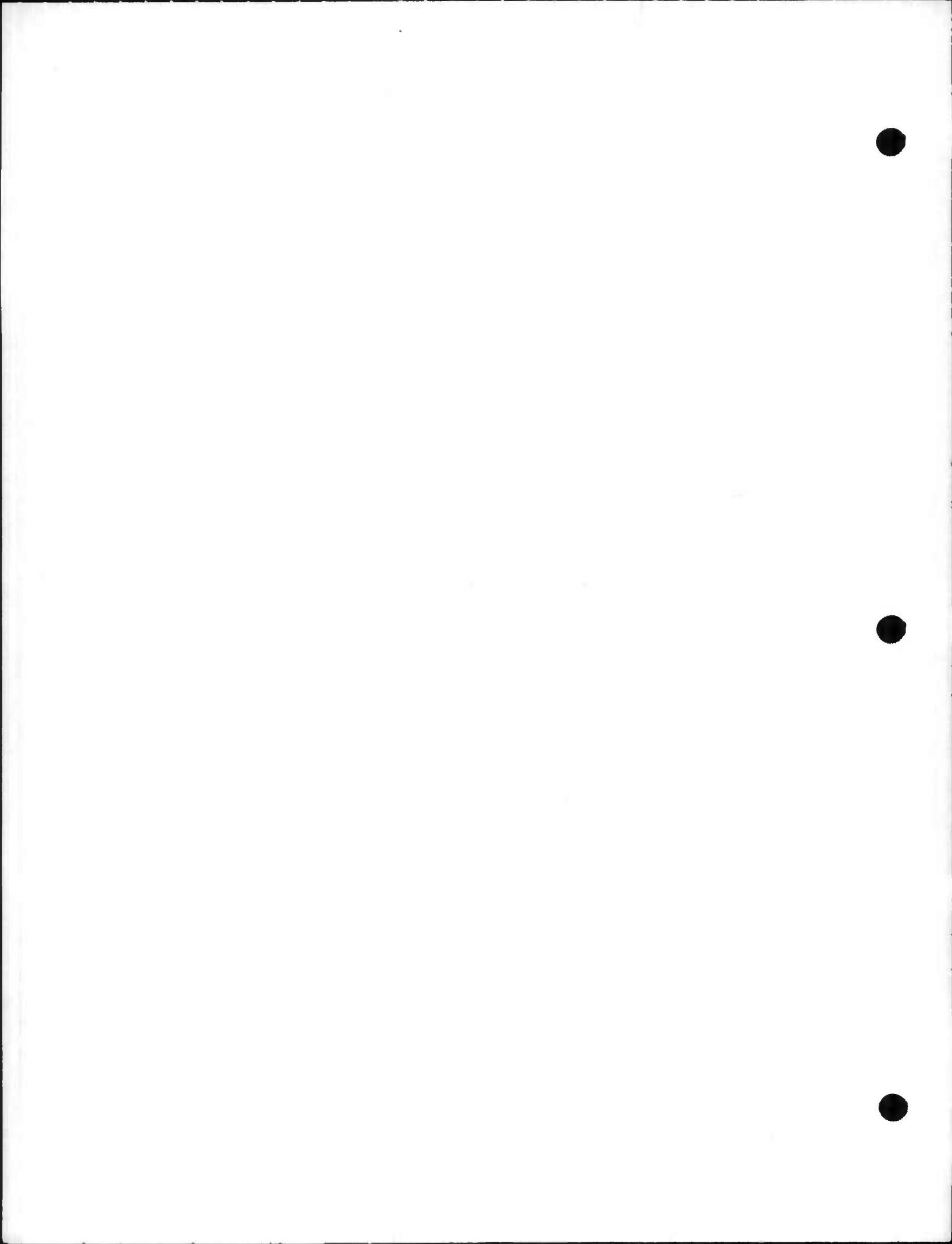
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH MAY DAY 31, YEAR 1995	3. TIME OF DEATH 4:45 A.M.	
EARL JOHNSON											7. DATE OF BIRTH (Month, Day, Year) DEC. 10, 1932		8. BIRTHPLACE (State or Foreign Country) PHILA. PENN
4. SOCIAL SECURITY NUMBER 577 36 4777			S. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.						
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSPITAL RESIDENCE OF DECEDENT											9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY		
10a. STATE D.C.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION WASHINGTON				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 1839 INDEPENDENCE AVENUE, S.E.					10f. ZIP CODE 20003			10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH.			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) FOREMAN			16b. KIND OF BUSINESS/INDUSTRY GOVT.							
17. FATHER'S NAME (First, Middle, Last) UNKNOWN					18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARA SMITH								
19a. INFORMANT'S NAME (Type/Print) MAY FAYE D. JOHNSON					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1839 independence AVE., SE, WASH., DC20003								
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) GLENWOOD CEMETERY			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 6/7			20c. LOCATION — City or Town, State WASHINGTON, D.C.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY E.M. DUDLEY FUNERAL HOME, 3200R.I.AVE., MT.RAINIER, MD20712								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death 9 days 7 days		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral aneurysm, ruptured DUE TO (OR AS A CONSEQUENCE OF) b. Status post neurosurgery DUE TO (OR AS A CONSEQUENCE OF)													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D05698											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. Thomas Foley, M.D., Prince George's Hospital Center, Cheverly, MD 20785		29d. DATE SIGNED (Month, Day, Year) ► 6/1/95											
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE John DeLoach, Registrar											

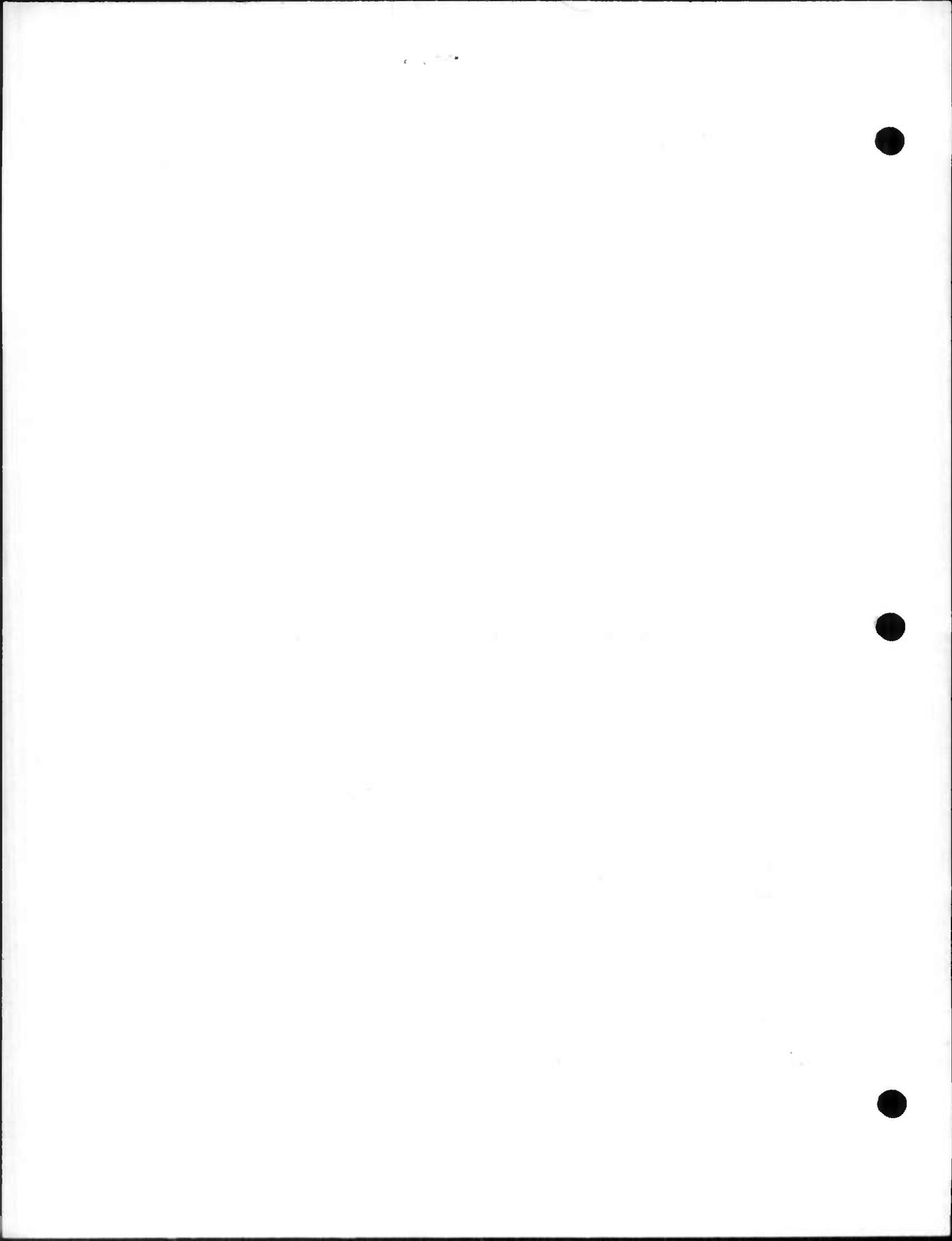


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		<i>Claudia Jean Jones</i>						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH HOUR MIN.			
4. SOCIAL SECURITY NUMBER 218-42-5798		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 51 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb 24, 1944		8. BIRTHPLACE (State or Foreign Country), Washington DC	
9a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Clinton						9c. COUNTY OF DEATH Prince George's					
RESIDENCE OF DECEASED													
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Lothian						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 194 Edward Lane								10f. ZIP CODE 20711		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES						13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed						16b. KIND OF BUSINESS/INDUSTRY Cleaner of Private Homes					
17. FATHER'S NAME (First, Middle, Last) Elijah C. Lee								18. MOTHER'S NAME (First, Middle, Maiden Surname) Jeannette A. Bivens					
19a. INFORMANT'S NAME (Type/Print) Robert Paul Jones		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 194 Edward Lane, Lothian, Md 20711											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans Cemetery						20c. LOCATION — City or Town, State Cheltenham, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertension, arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Prostectomy, Breast carcinoma - metastatic, 1990</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>								29c. LICENSE NUMBER D21230		29d. DATE SIGNED (Month, Day, Year) June 11, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Bayview Ct., Clifton Park, NY 12073-48</i>													
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Jane A. Wilson-Kardell</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

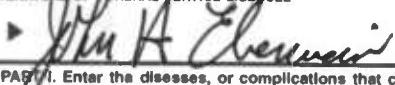
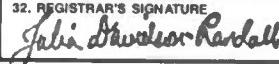
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

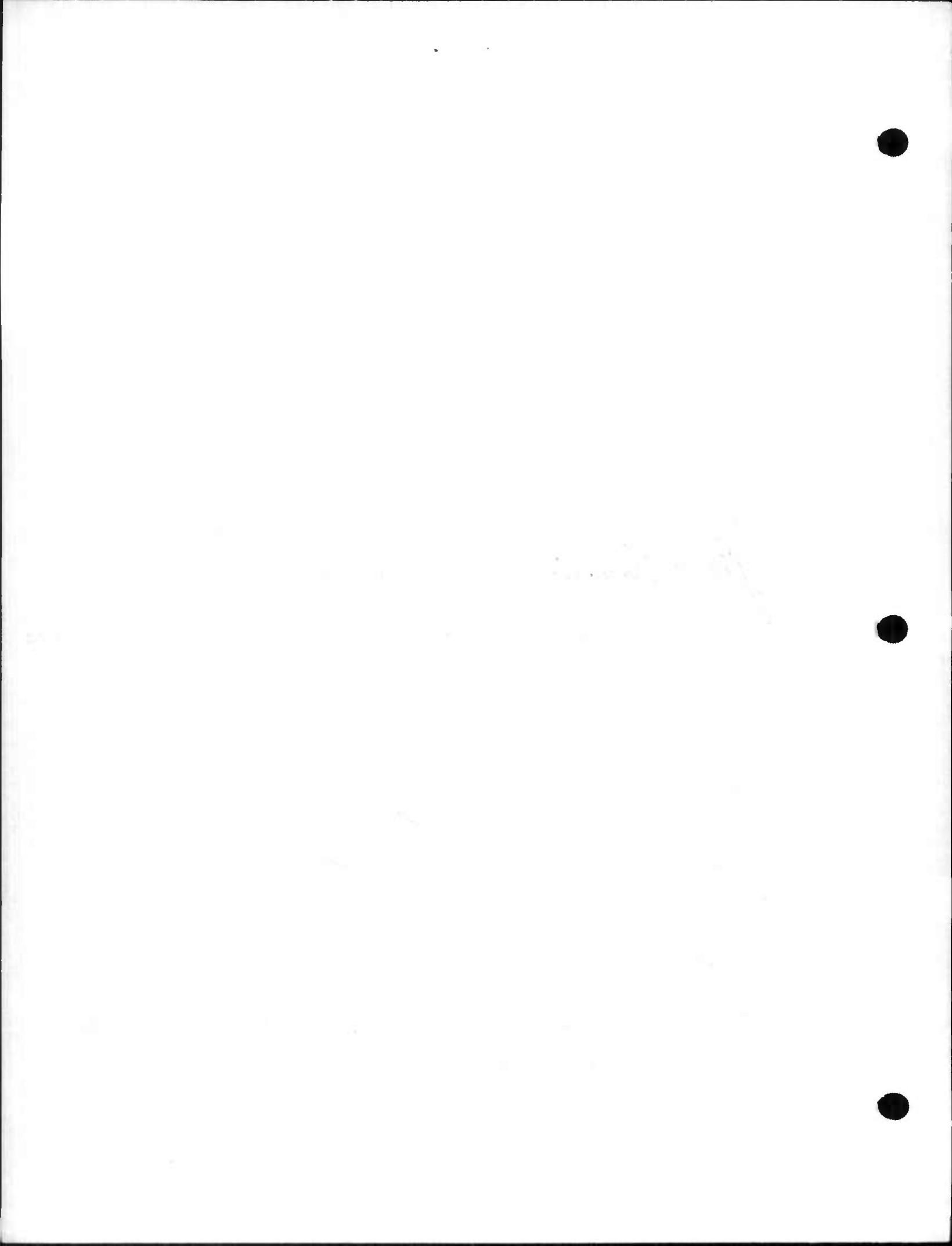
IMPORTANT: If Item 28 is marked, or if Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 12 1995										3. TIME OF DEATH 1:48 A M		
1. DECEDENT'S NAME (First, Middle, Last) RAY PETER JOHNSTON												7. DATE OF BIRTH (Month, Day, Year) Oct 20 1916		8. BIRTHPLACE (State or Foreign Country) Pennsylvania
4. SOCIAL SECURITY NUMBER 378-03-7181		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9. FACILITY NAME (If not institution, give street and number) 1995 Kings Landing Road		9b. CITY, TOWN OR LOCATION OF DEATH Huntington		9c. COUNTY OF DEATH CALVERT
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Huntington										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 1995 Kings Landing Road		10f. ZIP CODE 20639										10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		17. FATHER'S NAME (First, Middle, Last) Howard B. Johnston		18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Curran Johnston		19. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1995 Kings Landing Road Huntington, MD 20639		19b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. LOCATION — City or Town, State 6-13-95 Alexandria, VA		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory		20c. LOCATION — City or Town, State 6-13-95 Alexandria, VA										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		M00173		22. NAME AND ADDRESS OF FACILITY J.H. Eberwein Mortuary 4433 White Pkwy White Plains, MD 20695										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 5 months		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Squamous Cell Lung Cancer DUE TO (OR AS A CONSEQUENCE OF):														
b. _____ DUE TO (OR AS A CONSEQUENCE OF):														
c. _____ DUE TO (OR AS A CONSEQUENCE OF):														
d. _____														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Empty Sema												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D41794										29d. DATE SIGNED (Month, Day, Year) ► 6-12-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Priscella Callahan-Lyon MD 120 Hospital Rd #200 Prince Frederick, MD 20678														
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE 												



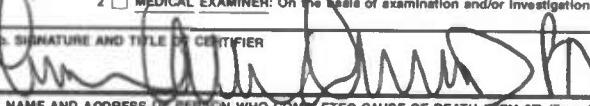
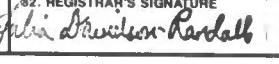
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH	
Clarence Rayfield Jones										June 7, 1995		5:00 A M	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
214-28-8912		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		66 YRS.		MONTHS		DAYS		HOURS MIN.			
8a. FACILITY NAME (If not institution, give street and number)										9a. COUNTY OF DEATH			
Washington Adventist Hospital										Takoma Park			
RESIDENCE OF DECEDENT													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
Maryland		Prince George's		Brentwood									
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?					
4323 40th Place		20722						USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
1 Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck driver				16b. KIND OF BUSINESS/INDUSTRY Wall products							
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Lucas Jones										Edna Jacks			
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Adele Jones										4323 40th Place Brentwood, Maryland 20722			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)										20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Coopers UM Church Cem. 6/10/95			
20c. LOCATION — City or Town, State Dunkirk, MD													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia													
b. Uremia DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia secondary to Uremia; Congestive Heart Failure; secondary to Coronary Artery Disease										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER Check only <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER D01499			
29d. DATE SIGNED (Month, Day, Year) ► June 7, 1995													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lewis Dennis, M.D. 6201 Greenbelt Rd., #U-1 College Park, MD 20740 67 1													
31. DATE FILED (Month, Day, Year) JUN 9 1995		32. REGISTRAR'S SIGNATURE 											

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH June 11, 1995 DAY YEAR								3. TIME OF DEATH 12:45 P M		
1. DECEDENT'S NAME (First, Middle, Last) Dorothy May Jones												
4. SOCIAL SECURITY NUMBER 022-01-7597		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month Day, Year) April 12, 1904		8. BIRTHPLACE (State or Foreign Country) Massachusetts		
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center										9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg	9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Gaithersburg								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 211 Russell Ave.					10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary			16b. KIND OF BUSINESS/INDUSTRY Chemical Company							
17. FATHER'S NAME (First, Middle, Last) Arthur H. Holyoke					18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice M. Bates							
19e. INFORMANT'S NAME (Type/Print) Sherlie H. Parr					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3701 International Dr., Silver Spring, Md. 20906-1555							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Montgomery Crematorium, Inc.			20c. LOCATION — City or Town, State Bethesda, Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Olin L. Molesworth					22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebral Thrombosis DUE TO (OR AS A CONSEQUENCE OF): b. Cerebral Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____										3 years		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										5 years		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide					26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M	26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	26d. DESCRIBE HOW INJURY OCCURED				
					26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFYING PHYSICIAN James R. Moore, Jr., M.D.					29c. LICENSE NUMBER 07231			29d. DATE SIGNED (Month, Day, Year) June 12, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James R. Moore, Jr., M.D.												
31. DATE FILED (Month, Day, Year) JUN 16 1995					32. REGISTRAR'S SIGNATURE Julia Shuler Harrell							

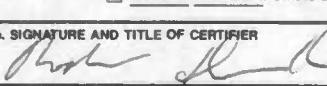
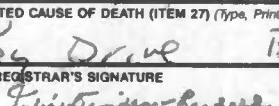
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH	
JUANITA T. JACKSON										JUNE 11, 1995		1915 M	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
217-42-5959		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		84						12-7-10		DEL.	
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
ATLANTIC GENERAL HOSPITAL										BERLIN		WORCESTER	
RESIDENCE OF DECEDENT													
10e. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?			
Md.	WORCESTER			OCEAN CITY						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER										10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
906 PHILADELPHIA AVE.										21842		USA	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: WHITE	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+) 4				HOMEMAKER						OWN HOME	
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)			
CHARLES H. TIMMONS										MAY JARMON			
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
ROBERT B. JACKSON										906 PHILA. AVE., OCEAN CITY, MD., 21842			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)					DATE	20c. LOCATION — City or Town, State		
					PARSONS CEMETERY					6/14	SALISBURY, MD. /		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										22. NAME AND ADDRESS OF FACILITY			
										ULLRICH FUNERAL HOME BERLIN, MD.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. cerebral vascular accident										12 hours			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
b. _____ c. _____ d. _____										DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
										<input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  physician		29c. LICENSE NUMBER H44283				29d. DATE SIGNED (Month, Day, Year) ► 6/11/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT DURGIN 9733 Healthway Drive Berlin, MD													
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE 											

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

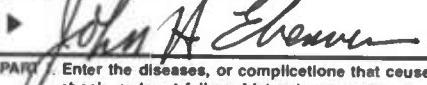
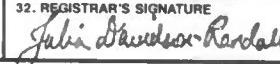
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

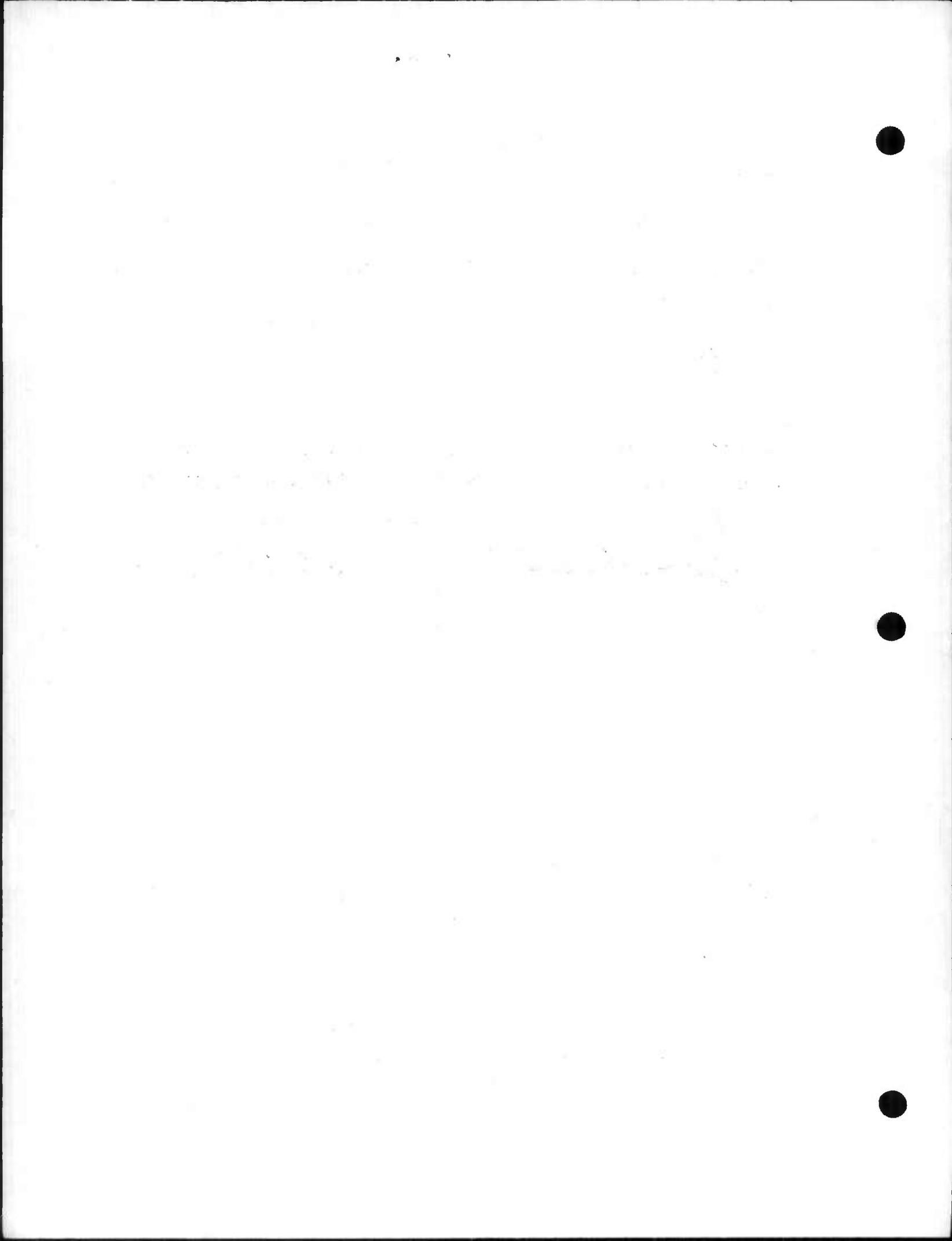
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Donald Christian Johansen											June 9, 1995	17:45 M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
218-30-8155		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	61 YRS.	MONTHS	DAYS	HOURS	MIN.	Feb 3 1934		Washington, DC		
9a. FACILITY NAME (If not institution, give street and number)											9b. CITY, TOWN OR LOCATION OF DEATH	
Calvert Memorial											Prince Frederick	
RESIDENCE OF DECEDENT											9c. COUNTY OF DEATH	
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland	St Mary's	Charlotte Hall										
10e. STREET AND NUMBER											10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
Route 2 Box 5											20622	USA
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951-1953				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:					14. RACE — American Indian, Black, White, etc. Specify: White	
Elementary/Secondary (0-12)		College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Unknown					16b. KIND OF BUSINESS/INDUSTRY Unknown	
17. FATHER'S NAME (First, Middle, Last)											18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Christian Johansen											Pearl Sorrell Johansen	
19a. INFORMANT'S NAME (Type/Print)											19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Marcus Brookbank											Route 2 Box 5 Charlotte Hall, MD 20622	
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Maryland Veterans Cem				DATE		20c. LOCATION — City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						6-14-95		Cheltenham, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 											22. NAME AND ADDRESS OF FACILITY J.H. Eberwein Mortuary 4433 White Pls La White Pls., MD 20695	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death 1 month	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. _____												
b. _____ DUE TO (OR AS A CONSEQUENCE OF): a chronic obstructive pulmonary disease												
c. _____ DUE TO (OR AS A CONSEQUENCE OF): a												
d. _____ DUE TO (OR AS A CONSEQUENCE OF): a												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. chronic obstructive pulmonary disease											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 											29c. LICENSE NUMBER D46314	29d. DATE SIGNED (Month, Day, Year) ► 6/10/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
Paul Pomilla M.D. Prince Frederick, M.d. 20678												
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE 										



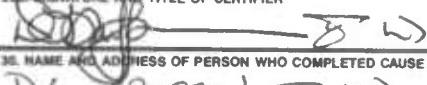
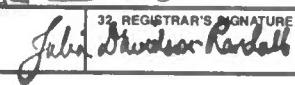
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

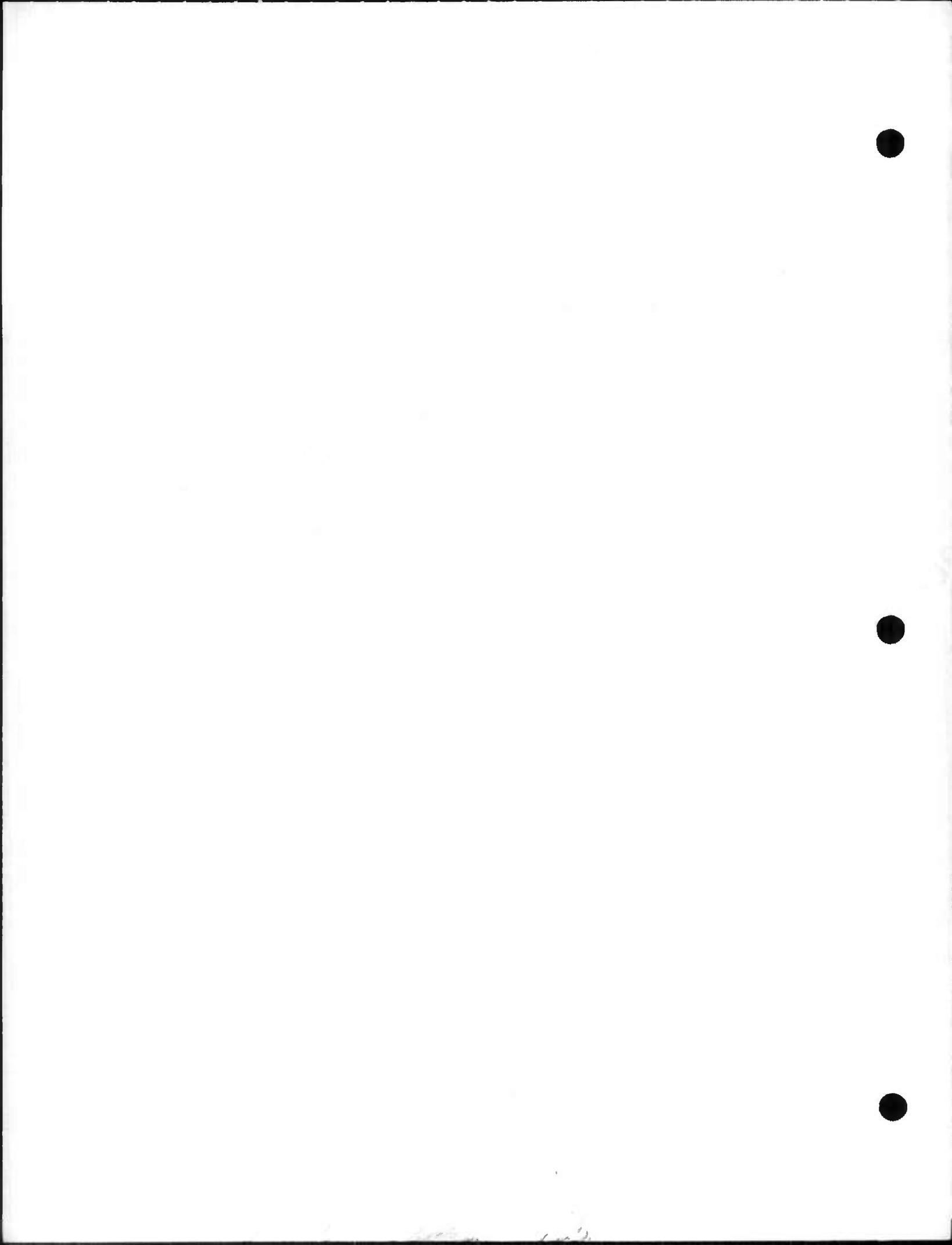
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) YEKATIRINA KAUFMAN										2. DATE OF DEATH MONTH JUNE DAY 8 , 1995 YEAR	3. TIME OF DEATH 5:55 A.M.
4. SOCIAL SECURITY NUMBER 215-21-3246		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.		7. DATE OF BIRTH (Month, Day, Year) DEC. 25, 1901		8. BIRTHPLACE (State or Foreign Country) RUSSIA			
9a. FACILITY NAME (If not institution, give street and number) 17100 DOWNING STREET #301				9b. CITY, TOWN OR LOCATION OF DEATH GAITHERSBURG				9c. COUNTY OF DEATH MONTGOMERY			
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION GAITHERSBURG								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 17100 DOWNING STREET #301				10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY OWN HOME			
17. FATHER'S NAME (First, Middle, Last) AKIVA BERKOVICH						18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHEL PUGACH					
19a. INFORMANT'S NAME (Type/Print) VICTOR GOROKHOV				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 OAK SHADE ROAD, GAITHERSBURG, MD 20878							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS				DATE 6/9	20c. LOCATION — City or Town, State OLNEY, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 3 MONTHS	
IMMEDIATE CAUSE (First disease or condition resulting in death) → a. ISCHEMIC CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF):											
{ b. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY INSUFFICIENCY, HYPERTENSION, DIABETES										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D4210		29d. DATE SIGNED (Month, Day, Year) JUNE 8, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. GRIFFEN III MD 15225 SHADY GROVE RD ROCKVILLE, MARYLAND											
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

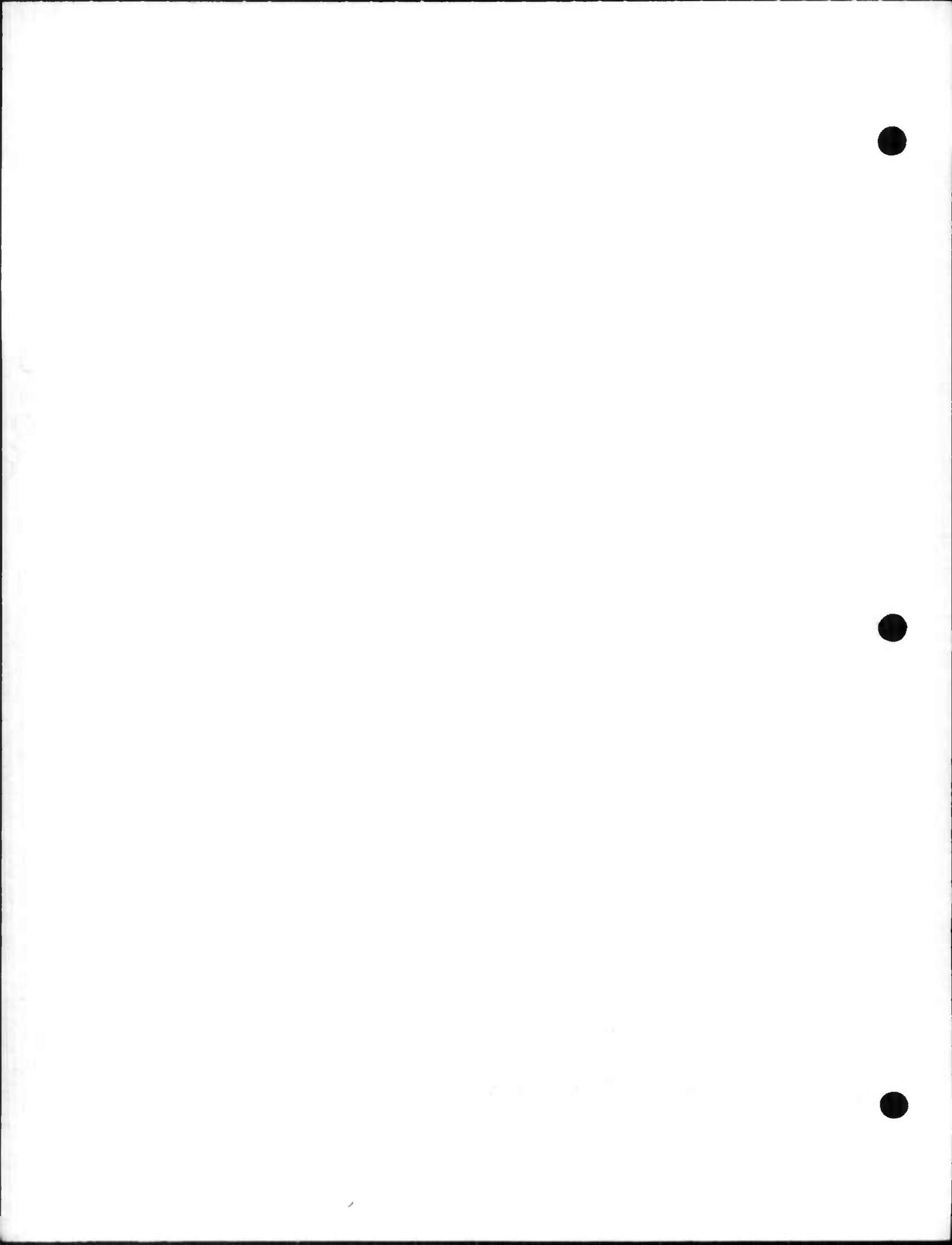
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. 95 19065
1. DECEASED'S NAME (First, Middle, Last)		KEO					2. DATE OF DEATH MONTH JUNE DAY 2 YEAR 95		3. TIME OF DEATH AM 7:41 AM
4. SOCIAL SECURITY NUMBER 577-04-9473		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 yrs.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) Aug. 12, 1932		8. BIRTHPLACE (State or Foreign Country) Kampuchea	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park					9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEASED									
10a. STATE Maryland	10b. COUNTY Prince George	10c. CITY, TOWN OR LOCATION Hyattsville					10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 1400 East West Highway		10f. ZIP CODE 20783					10g. CITIZEN OF WHAT COUNTRY? United States Perm. Resident		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Asian	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0 Stable Worker			16b. KIND OF BUSINESS/INDUSTRY Education				
17. FATHER'S NAME (First, Middle, Last) Nuth Rath		18. MOTHER'S NAME (First, Middle, Maiden Surname) Hem Puth							
19a. INFORMANT'S NAME (Type/Print) Nith Ros		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1400 East West Highway, Hyattsville, Maryland 20783							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Crematory			DATE 6/5	20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Nuth</i>		22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Arteriosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>4 years</i></p> <p>b. _____</p> <p>c. _____</p> <p>d. _____</p>									
Approximate Interval Between Onset and Death									
<p>Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>{</p>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Nuth</i>		31. DATE FILED (Month, Day, Year) JUN 07 1995					32. REGISTRAR'S SIGNATURE <i>John Nuth</i>	33. LICENSE NUMBER DOS 546	34. DATE SIGNED (Month, Day, Year) JUN 2 95

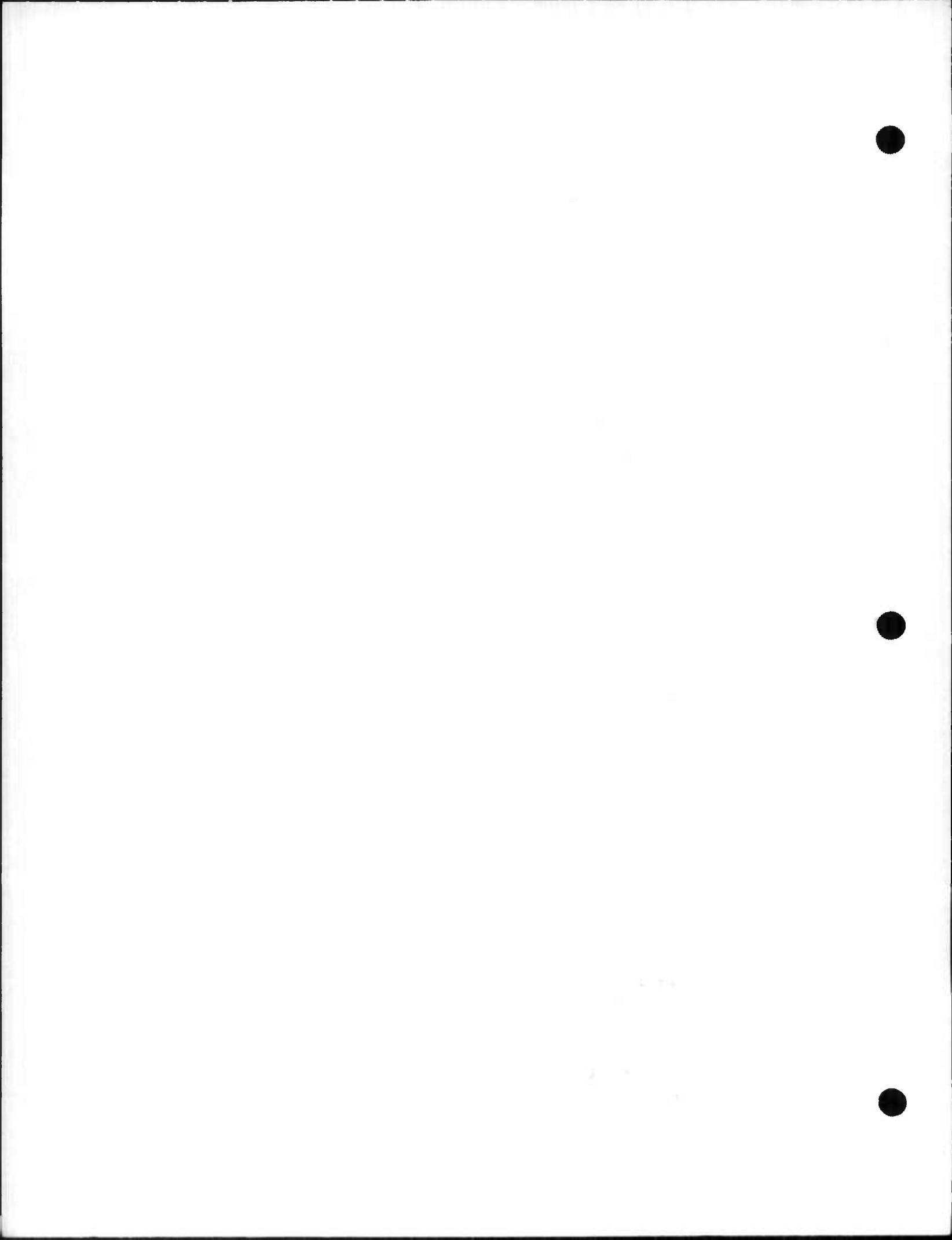


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Amended #1, 6/7/95, JW, Montgomery Co. 95 19066

1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <i>Kim Eui-soo Eui Soo Kim</i>												2. DATE OF DEATH MONTH JUNE DAY 4 YEAR 1995	3. TIME OF DEATH 11:00 AM
4. SOCIAL SECURITY NUMBER 586-48-3200		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct. 14, 1942		8. BIRTHPLACE (State or Foreign Country) Korea			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 11801 Rockville Pike, Apt. 1115				10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? Korea					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Korean					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Engineer			16b. KIND OF BUSINESS/INDUSTRY Air Conditioning								
17. FATHER'S NAME (First, Middle, Last) Young-Chan Kim				18. MOTHER'S NAME (First, Middle, Maiden Surname) Yoon-Sie Lee									
19a. INFORMANT'S NAME (Type/Print) Won-Young Kim				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11801 Rockville Pike, Apt. 1115, Rockville, MD 20852									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Norbeck Memorial Park				DATE 6/7	20c. LOCATION — City or Town, State Olney, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Laine L Phillips</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. <i>Cardiac Arrest</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>Intracerebral Hemorrhage</i>													
b. <i>Uncontrolled Hypertension</i>													
c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>													
d. <i></i>													
Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>S. Angra, MD</i>		29c. LICENSE NUMBER D 36980				29d. DATE SIGNED (Month, Day, Year) ► 6/4/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Satish Angra 344 University Blvd. W. Silver Spring, Md. 20901													
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE <i>J. Angra, MD</i>											



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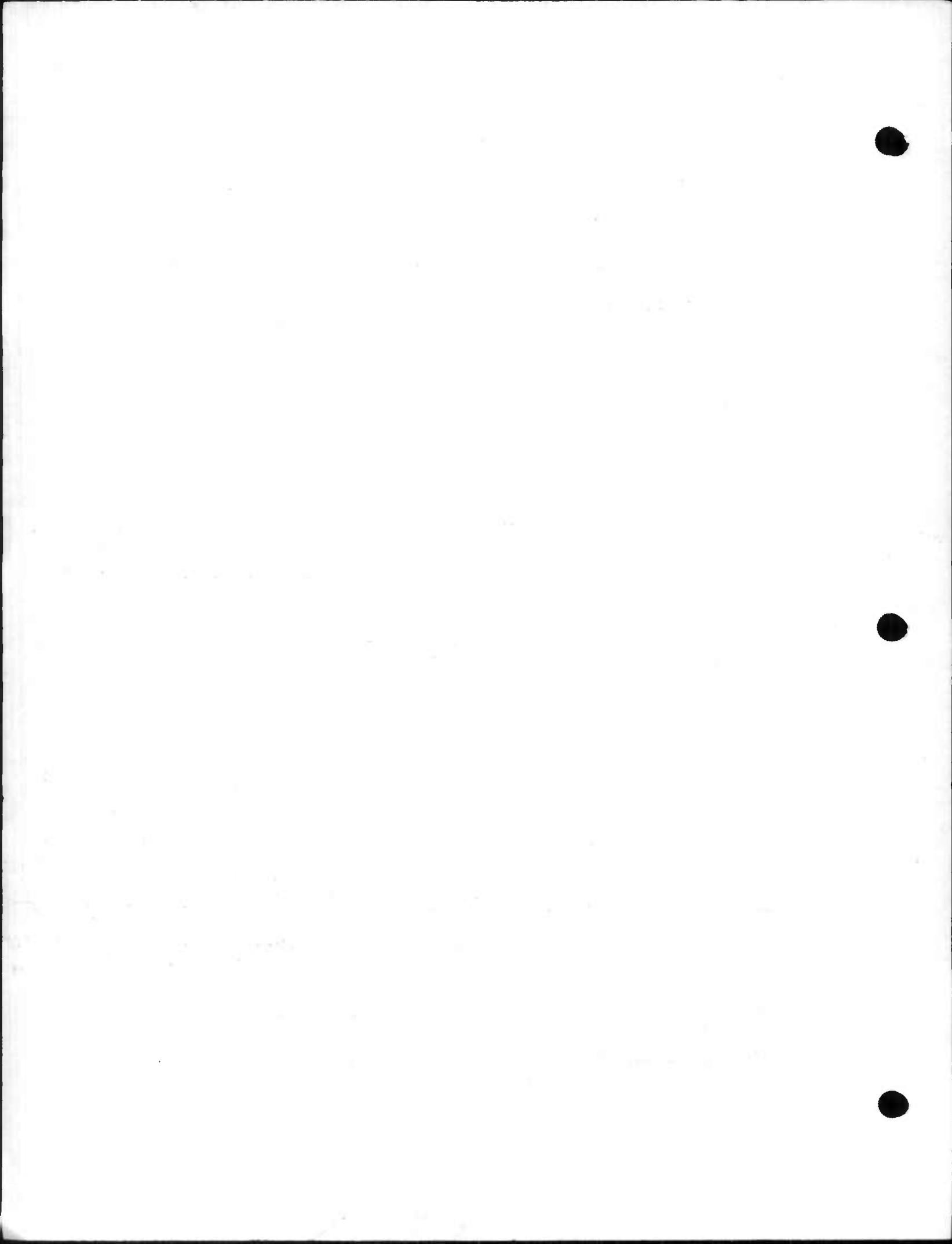
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
PETER KIMM, JR.											JUNE 4, 1995	0310 A M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
212-76-9715		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	36 YRS.	MONTHS	DAYS	HOURS	MIN.	June 25, 1958		New York		
9a. FACILITY NAME (If not institution, give street and number)											9b. CITY, TOWN OR LOCATION OF DEATH	
CLARA BARTON PARKWAY & #495											9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT											MONTGOMERY	
10e. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
Maryland	Montgomery	Potomac										
10e. STREET AND NUMBER											10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
8505 Horseshoe Lane											20854	United States
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12)		College (14 or 5+)				Attorney				Law Firm		
17. FATHER'S NAME (First, Middle, Last)											18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Peter M. Kimm											Grace Anderson	
19a. INFORMANT'S NAME (Type/Print)											19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Virginia Fowler Kimm											Same as 10	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State				
		Gate of Heaven Cemetery				6-8		Silver Spring, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eileen H. Rapp</i>											22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. <i>Multiple Injuries</i> DUE TO (OR AS A CONSEQUENCE OF):												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i> DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) ROADWAY										
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6/14/95		28b. TIME OF INJURY 0304 M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>Subject drove struck road sign</i>				
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) roadway								28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>Clara Barton Parkway at Interstate 95, Montgomery County, Maryland</i>				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theodore M. Kippins</i>								29c. LICENSE NUMBER O.C.M.E	29d. DATE SIGNED (Month, Day, Year) ► JUNE 5, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) THEODORE M. KIPPINS 111 Penn Street, Baltimore, Maryland 21201		31. DATE FILED (Month, Day, Year) JUN 07 1995								32. REGISTAR'S SIGNATURE <i>John W. Kippins</i>		



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

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TO BE COMPLETED BY FUNERAL DIRECTOR

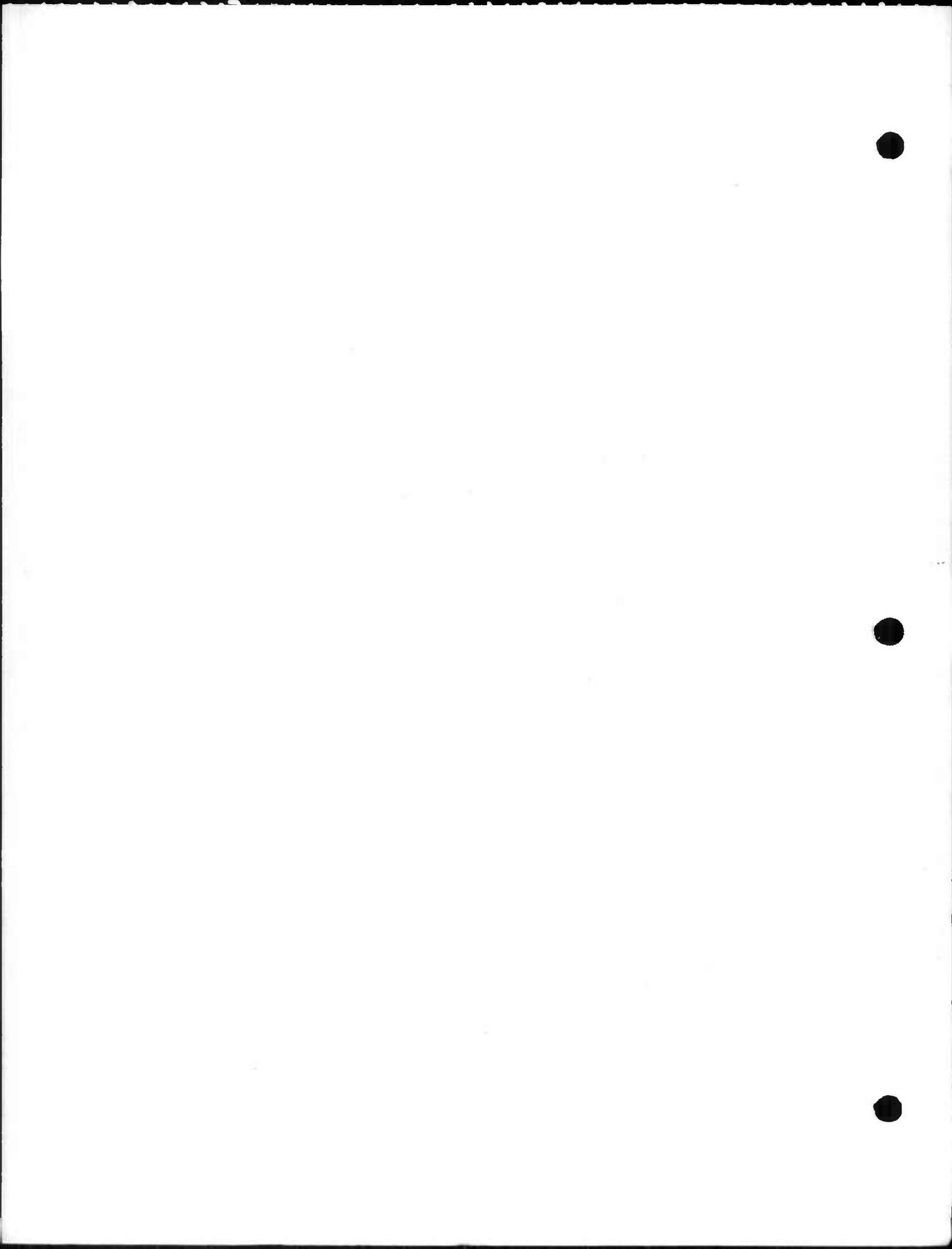
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19068

1. DECEDENT'S NAME (First, Middle, Last) KEUM SOON KIM						2. DATE OF DEATH MONTH DAY YEAR June 2, 1995	3. TIME OF DEATH 8:30 P.M.	
4. SOCIAL SECURITY NUMBER 212-39-3859		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 MONTHS 0 DAYS 0 HOURS 0 MIN.	7. DATE OF BIRTHN (Month, Day, Year) May 10, 1917	8. BIRTNPLACE (State or Foreign Country) Korea		
9a. FACILITY NAME (If not institution, give street and number) 17004 Downing Street				9b. CITY, TOWN OR LOCATION OF DEATHN Gaithersburg		9c. COUNTY OF DEATH Montgomery		
10e. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 17004 Downing Street				10f. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? Korea		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Korean	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Housewife			16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Sung Pyo Bae				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kyung Park				
19e. INFORMANT'S NAME (Type/Print) Woon Kyong Kim				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17004 Downing Street, Gaithersburg, Maryland 20877				
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Norbeck Memorial Park			DATE 6/6	20c. LOCATION — City or Town, State Norbeck, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael D. Gilbar				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877				
23. PART I. Enter the diseaseee, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):								
b. Asthma DUE TO (OR AS A CONSEQUENCE OF):								
c. Hypertension DUE TO (OR AS A CONSEQUENCE OF):								
d.								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29d. DATE SIGNED (Month, Day, Year) ► June 5, 1995	
29b. SIGNATURE AND TITLE OF CERTIFIER Boo K. Kim, M.D.		29c. LICENSE NUMBER D 13621						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Boo K. Kim, M.D., 8921 Shady Grove Court, Gaithersburg, Maryland 20877								
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE Julie Shuler Marshall						

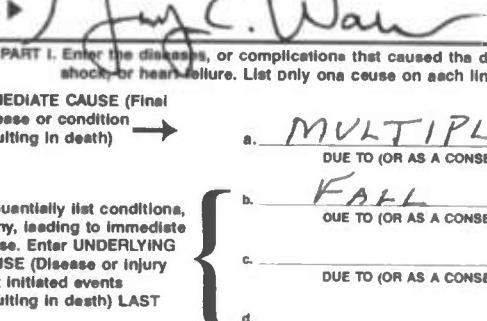
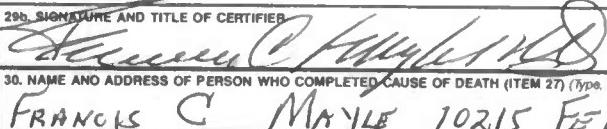
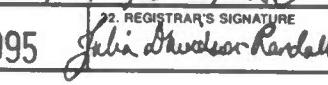


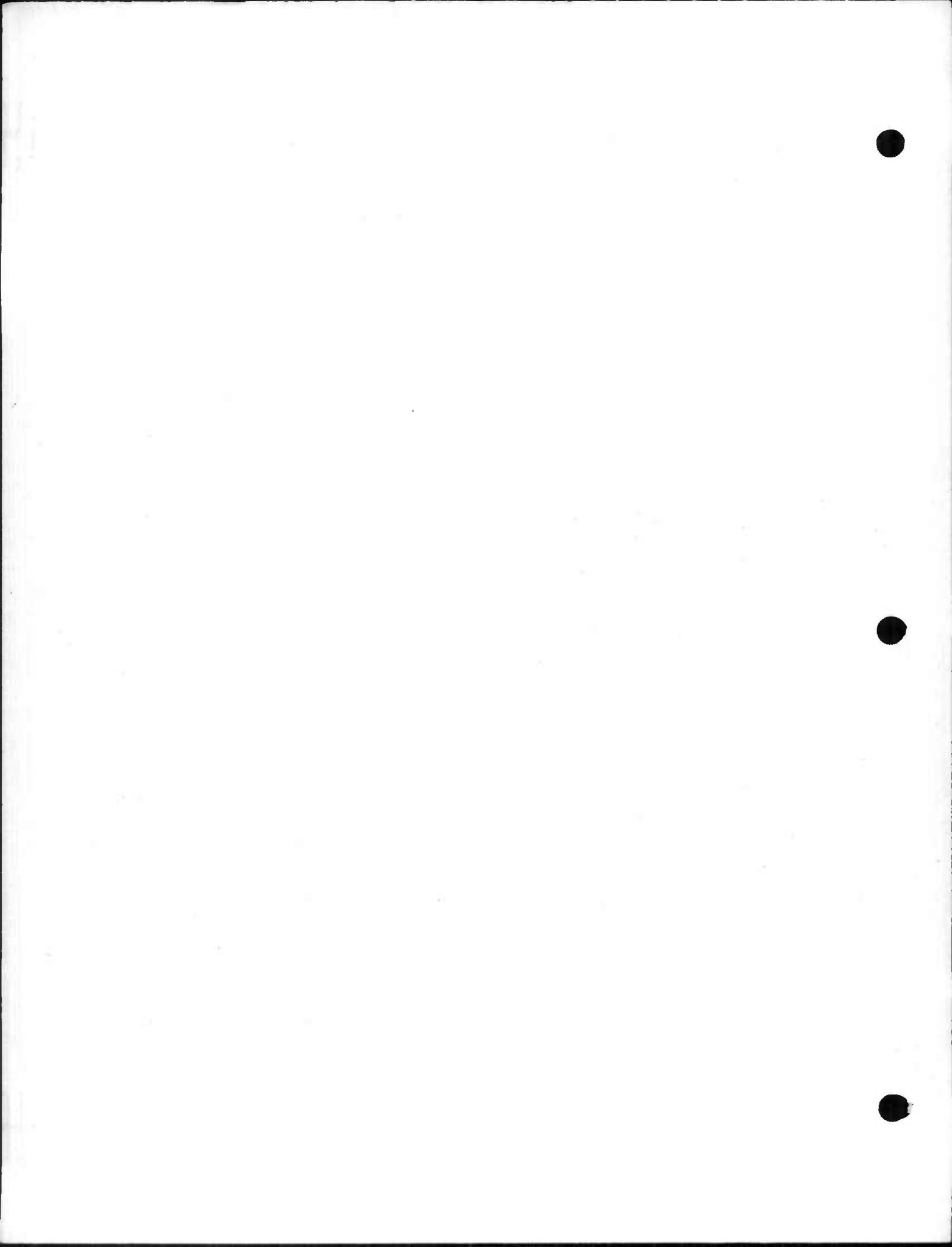
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR												95 19069			
1. DECEDENT'S NAME (First, Middle, Last) JUNE HODGE KIRKHAM												2. DATE OF DEATH MONTH JUNE DAY 2 YEAR 95	3. TIME OF DEATH 10:36 AM		
4. SOCIAL SECURITY NUMBER 577-01-4828		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 2, 1916		8. BIRTHPLACE (State or Foreign Country) Idaho					
9a. FACILITY NAME (If not institution, give street and number) 5332 Westpath Way												9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 5332 Westpath Way				10f. ZIP CODE 20816				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home											
17. FATHER'S NAME (First, Middle, Last) David Hodge				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rowena Tanner											
19a. INFORMANT'S NAME (Type/Print) Bruce H. Kirkham				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20448 Watkins Meadow Dr. Germantown, MD 20876											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Cemetery		DATE 6/6		20c. LOCATION — City or Town, State Rockville, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Joseph Gawler's Sons 5130 WI Ave. NW Washington, D.C. 20016													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death ACUTE			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF):													
		b. FALL DUE TO (OR AS A CONSEQUENCE OF):													
		c. DUE TO (OR AS A CONSEQUENCE OF):													
		d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PARKINSONISM												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) JUNE 1 95		28b. TIME OF INJURY A M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED FELL DOWN STEPS									
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) HOME						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D07099				29d. DATE SIGNED (Month, Day, Year) JUNE 2 95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817															
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE 													



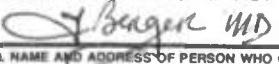
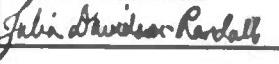
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

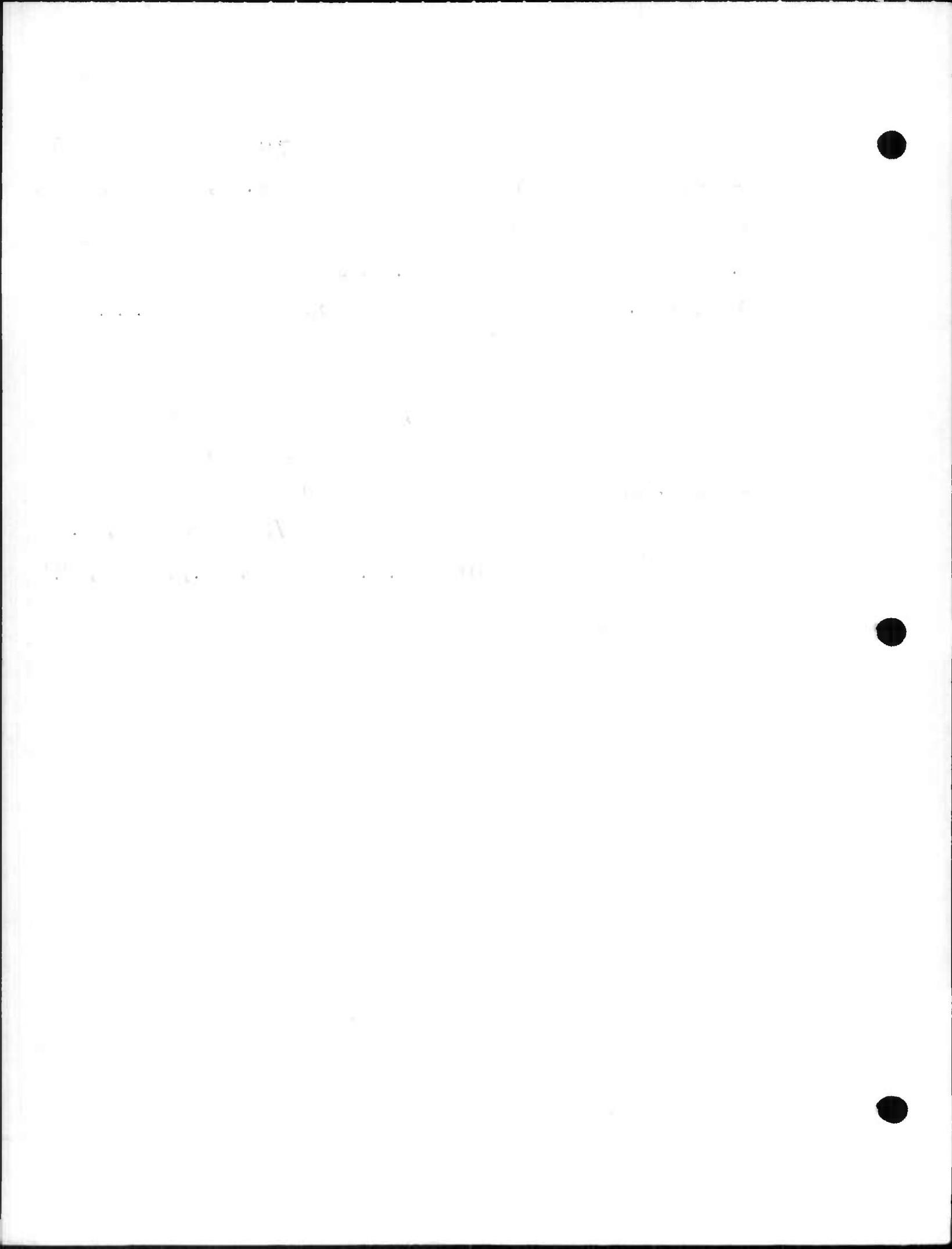
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or if Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		KLIMEK								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 10:27 p.m.			
VACLAV										JUNE 1 1995					
4. SOCIAL SECURITY NUMBER 210-14-1766		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) AUG. 11, 1921		8. BIRTHPLACE (State or Foreign Country) CZECHOSLOVAKIA			
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY								9c. COUNTY OF DEATH PRINCE GEORGE'S					
10e. STATE MD.		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION MT. RAINIER								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4208 34th ST.		10f. ZIP CODE 20712								10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:								14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+		16b. KIND OF BUSINESS/INDUSTRY ARRANGER, COMPOSER								MUSIC			
17. FATHER'S NAME (First, Middle, Last) VACLAV		16. MOTHER'S NAME (First, Middle, Maiden Surname) LUDMILA rov SUSAKOVA													
18e. INFORMANT'S NAME (Type/Print) ELIZABETH A. KLIMEK		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ITEM #10													
20e. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY								DATE 6/7		20c. LOCATION — City or Town, State RIVERDALE, MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY MO0091 W. W. CHAMBERS CO. INC., RIVERDALE, MD.													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. VENTRICULAR Fibrillation DUE TO (OR AS A CONSEQUENCE OF):												moments			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST b. CONGESTIVE Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____												years			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide e. <input type="checkbox"/> Could not be determined		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
								28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)							
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D25925								29d. DATE SIGNED (Month, Day, Year) ► June 6, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BERGER MD #205, 7720 Wisconsin Ave, Bethesda, Md 20814															
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE 													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

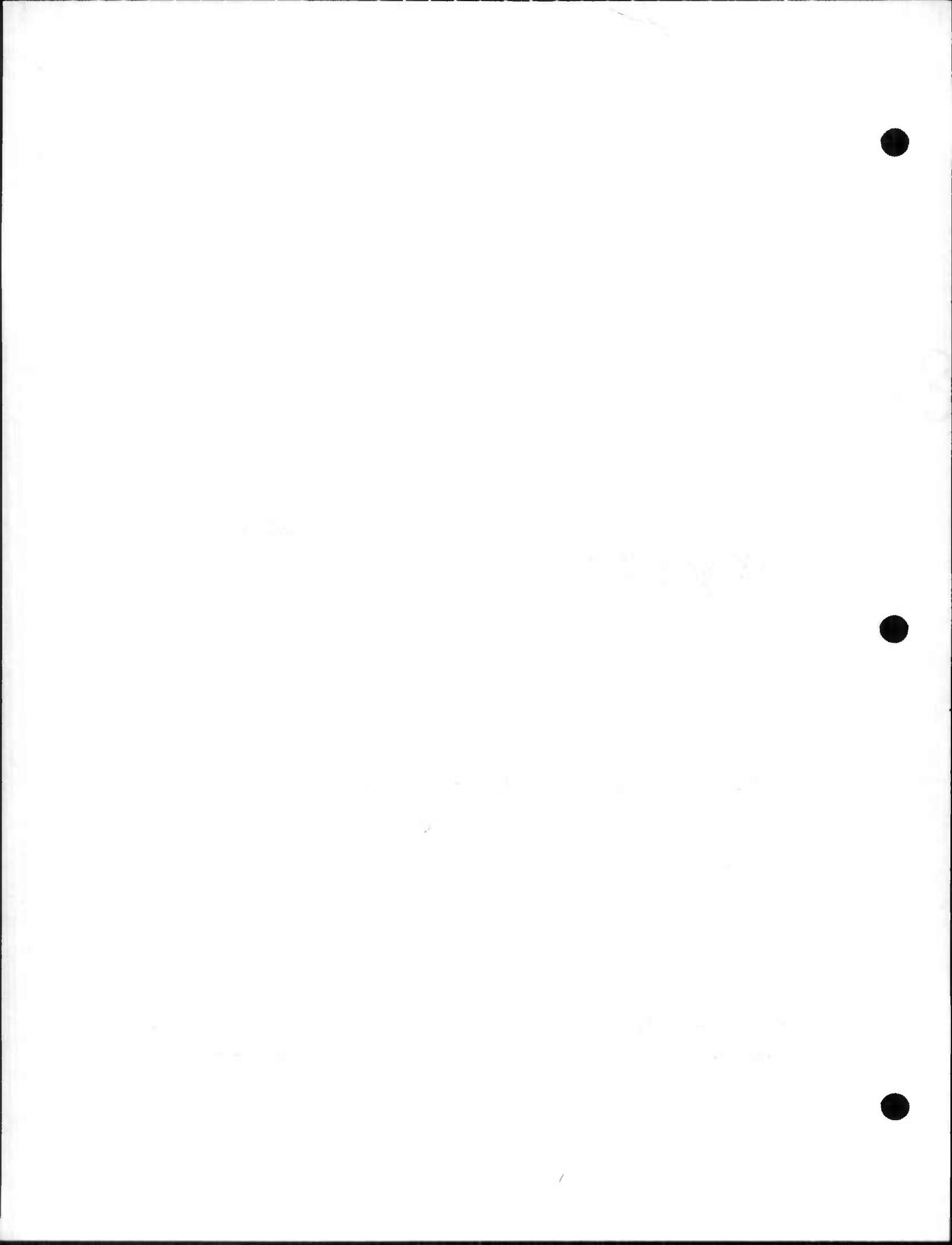
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19071

1. DECEDENT'S NAME (First, Middle, Last) ELIZABETH Z KINCAID												2. DATE OF DEATH MONTH JUNE DAY 6, YEAR 1995	3. TIME OF DEATH 5:03 P.M.		
4. SOCIAL SECURITY NUMBER 234-03-2392		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) NOVEMBER 25 1919		8. BIRTHPLACE (State or Foreign Country) OHIO					
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL												9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY	
10a. STATE WV		10b. COUNTY MINERAL		10c. CITY, TOWN OR LOCATION KEYSER		10f. ZIP CODE 26726		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER ROUTE 2 BOX 107												10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2		16b. KIND OF BUSINESS/INDUSTRY Transamerica/ADEL Manufacturer											
17. FATHER'S NAME (First, Middle, Last) ALEX ZETTY												18. MOTHER'S NAME (First, Middle, Maiden Surname) (UNKNOWN)			
19a. INFORMANT'S NAME (Type/Print) JOHN (JACK) KINCAID				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HC 86, BOX 434, FT. ASHBY, WV 26719											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WHITE CHAPEL MEML. GDNS.				DATE	20c. LOCATION — City or Town, State BARBOURSVILLE, WV						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathy A. Yurchuck</i>				22. NAME AND ADDRESS OF FACILITY FT. ASHBY FUNERAL HOME, INC. P.O. BOX 1260-FT. ASHBY, WV 26719											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Asystole												1½ hrs.			
DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease												10 yrs.			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 1 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER <input checked="" type="checkbox"/> MEDICAL EXAMINER		29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29c. SIGNATURE AND TITLE OF CERTIFIER <i>Reed A. Erickson ms</i>		29d. LICENSE NUMBER D42840		29e. DATE SIGNED (Month, Day, Year) 6/6/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Reed A. Erickson ms 900 SETON DR CUMBERLAND MD 21502		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Hardall</i>													
31. DATE FILED (Month, Day, Year) JUN 08 1995															



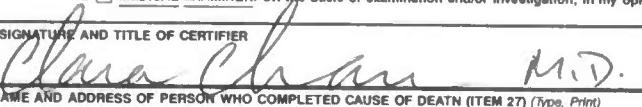
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

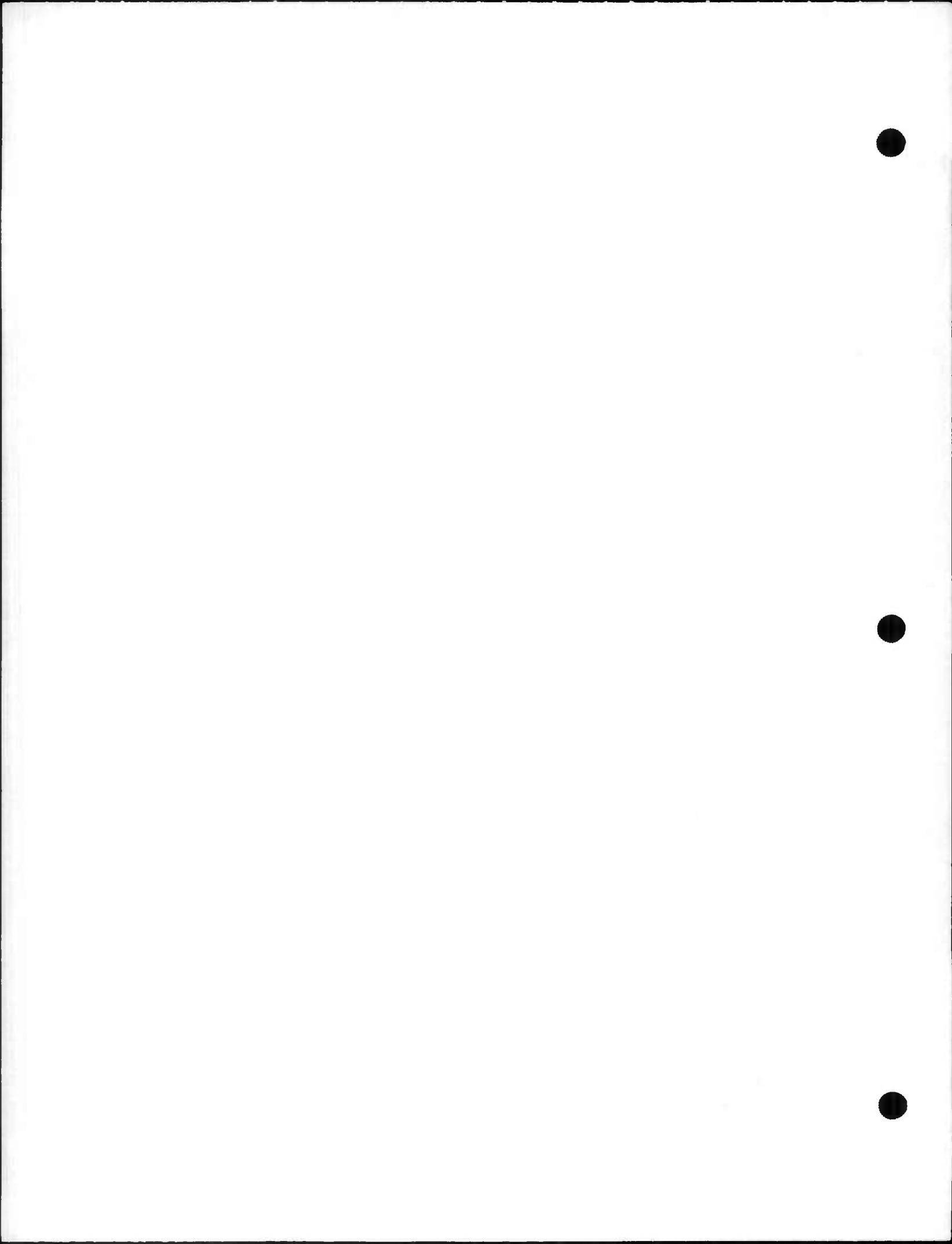
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR											
1. DECEASED'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 12:30 P. M
VIRGINIA MAE KENNEDY										MAY 30, 1995	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
218-38-5209		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	55 YRS.	MONTHS	DAYS	HOURS	MIN.			Dec. 18, 1939	Maryland
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
5002 Geronimo Street										College Park	Prince George's
RESIDENCE OF DECEASED											
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
Maryland	Prince George's			College Park							
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
5002 Geronimo Street				20740				United States			
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 8		Fabric Technician				Textile Industry					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Harry Taylor Houchens, Sr.										Dorothy Louise Jenkins	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Billy R. Kennedy										5002 Geronimo Street, College Park, MD 20740	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE	20c. LOCATION — City or Town, State		
				Fort Lincoln Cemetery				6/2/95	Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										22. NAME AND ADDRESS OF FACILITY	
										Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Lung Cancer										6 Months	
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER  Clara Chan, M.D.		29c. LICENSE NUMBER D41828				29d. DATE SIGNED (Month, Day, Year) ► May 31, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clara Chan, M.D., 7525 Greenway Center Drive, #205, Greenbelt, Maryland 20770											
31. DATE FILED (Month, Day, Year) JUN 2 1995		32. REGISTRAR'S SIGNATURE 									



95 19073

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH A.M. P.M.	
Vernon Worley Kirk		JUNE 6 95				1002 A.M.	
4. SOCIAL SECURITY NUMBER <u>223-14-6245</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH Elkton				9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEASED							
10a. STATE Md.	10b. COUNTY Cecil	10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER A-26 Union Church Road			10f. ZIP CODE 21921			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Well Driller			16b. KIND OF BUSINESS/INDUSTRY Construction		
17. FATHER'S NAME (First, Middle, Last) Worley Kirk				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Phillis Lander				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 197 Frenchtown Rd., Elkton, Md. 21921			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Kirk Cemetery			DATE 6/10/95	20c. LOCATION — City or Town, State Sugar Grove, Va.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Evelyn M. Keen</i>			22. NAME AND ADDRESS OF FACILITY Gee Funeral Home			259 E. Main St., Elkton, Md. 21921	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular Accident RT</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>No Q wave Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death 8 days 8 days 8 days 8 days							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension Severe & Labile</i>							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 22307		29d. DATE SIGNED (Month, Day, Year) ► 6/6/95 —			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SATANTILAL K. PATEL MD - 123 Stengerly Ave, ELKTON MD 21921							
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE <i>Jahnie Walker-Randall</i>					

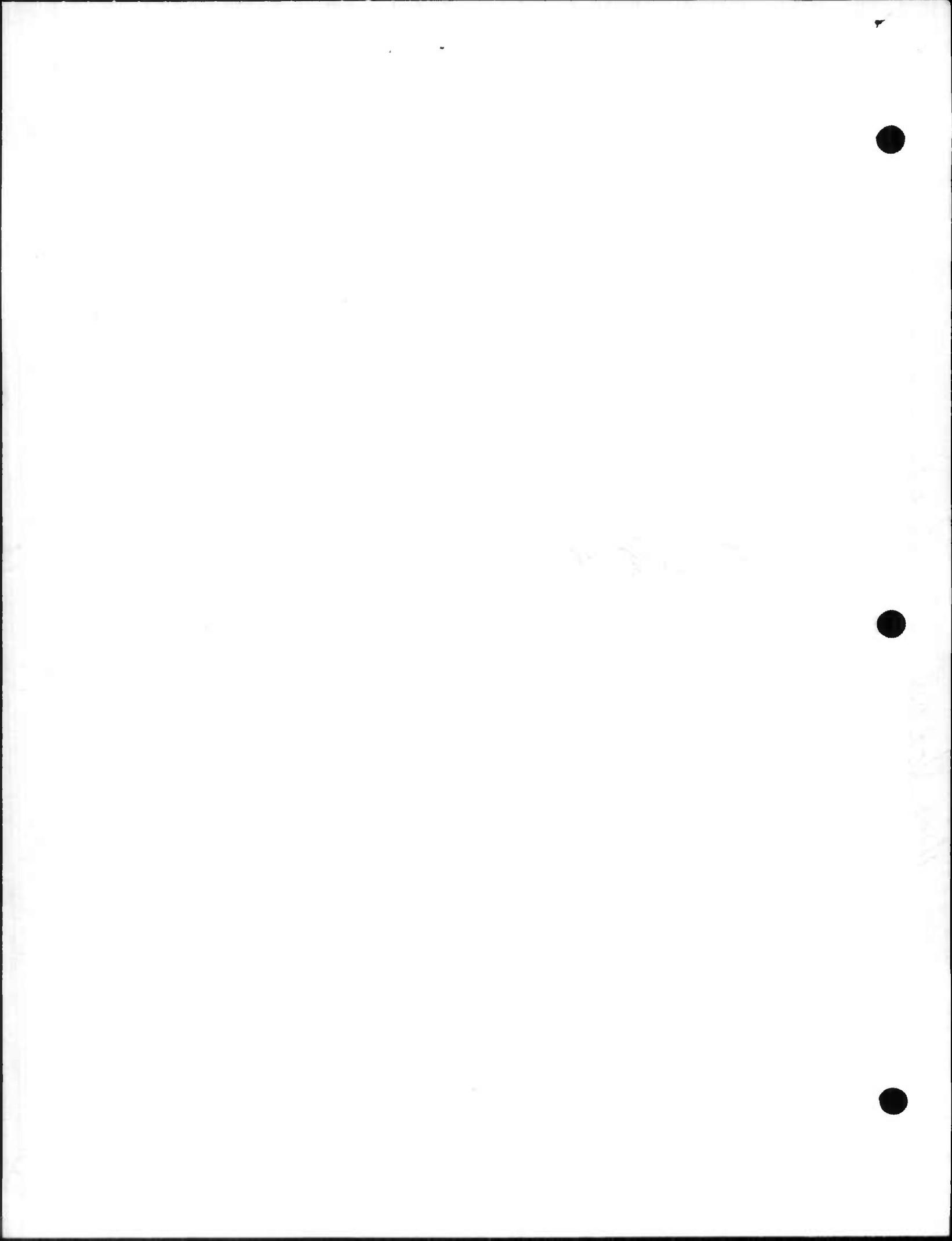
DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 68760

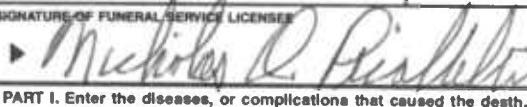
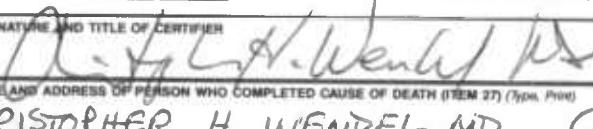
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

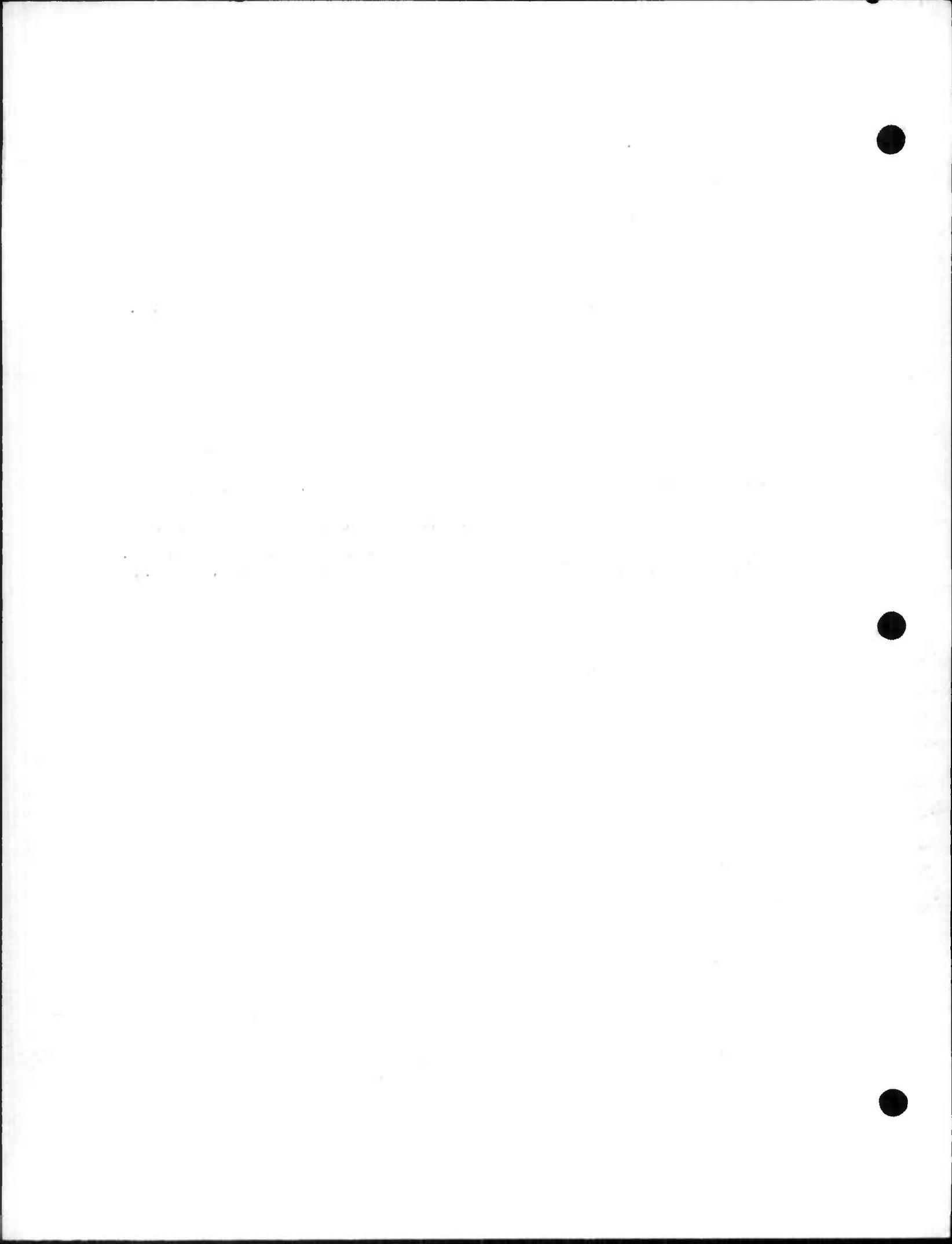
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last) Mildred S. Kachel											2. DATE OF DEATH MONTH DAY YEAR JUNE 3 1995	3. TIME OF DEATH M 0216		
4. SOCIAL SECURITY NUMBER 185-09-0499		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) 1/11/07					8. BIRTHPLACE (State or Foreign (Country) New York				
9a. FACILITY NAME (If not institution, give street and number) Union Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Elkton					9c. COUNTY OF DEATH Cecil					
RESIDENCE OF DECEDENT														
10a. STATE MD	10b. COUNTY Cecil	10c. CITY, TOWN OR LOCATION Elkton									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 6184 Telegraph Road				10f. ZIP CODE 21921					10g. CITIZEN OF WHAT COUNTRY? U.S.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home								
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Brownell										
19e. INFORMANT'S NAME (Type/Print) Kathryn Hall				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6184 Telegraph Rd. Elkton, MD 21921										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) All Saints Cemetery					DATE	20c. LOCATION — City or Town, State Newark, De				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY McCrary Funeral Homes, Inc. 3924 Concord Pike, Wilm., DE 19803										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Acute Myocardial Infarction</u> DUE TO (DR AS A CONSEQUENCE OF): b. <u>Coronary Artery Disease</u> DUE TO (DR AS A CONSEQUENCE OF): c. _____ DUE TO (DR AS A CONSEQUENCE OF): d. _____														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURED						
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29f. SIGNATURE AND TITLE OF CERTIFIER 		29g. LICENSE NUMBER D31154		29d. DATE SIGNED (Month, Day, Year) ► 6-5-95										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHRISTOPHER H. WENDEL MD G-38 OMEGA DR NEWARK DE 19725														
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 												



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any Injury, or other traumatic event, the medical examiner must be notified at once.

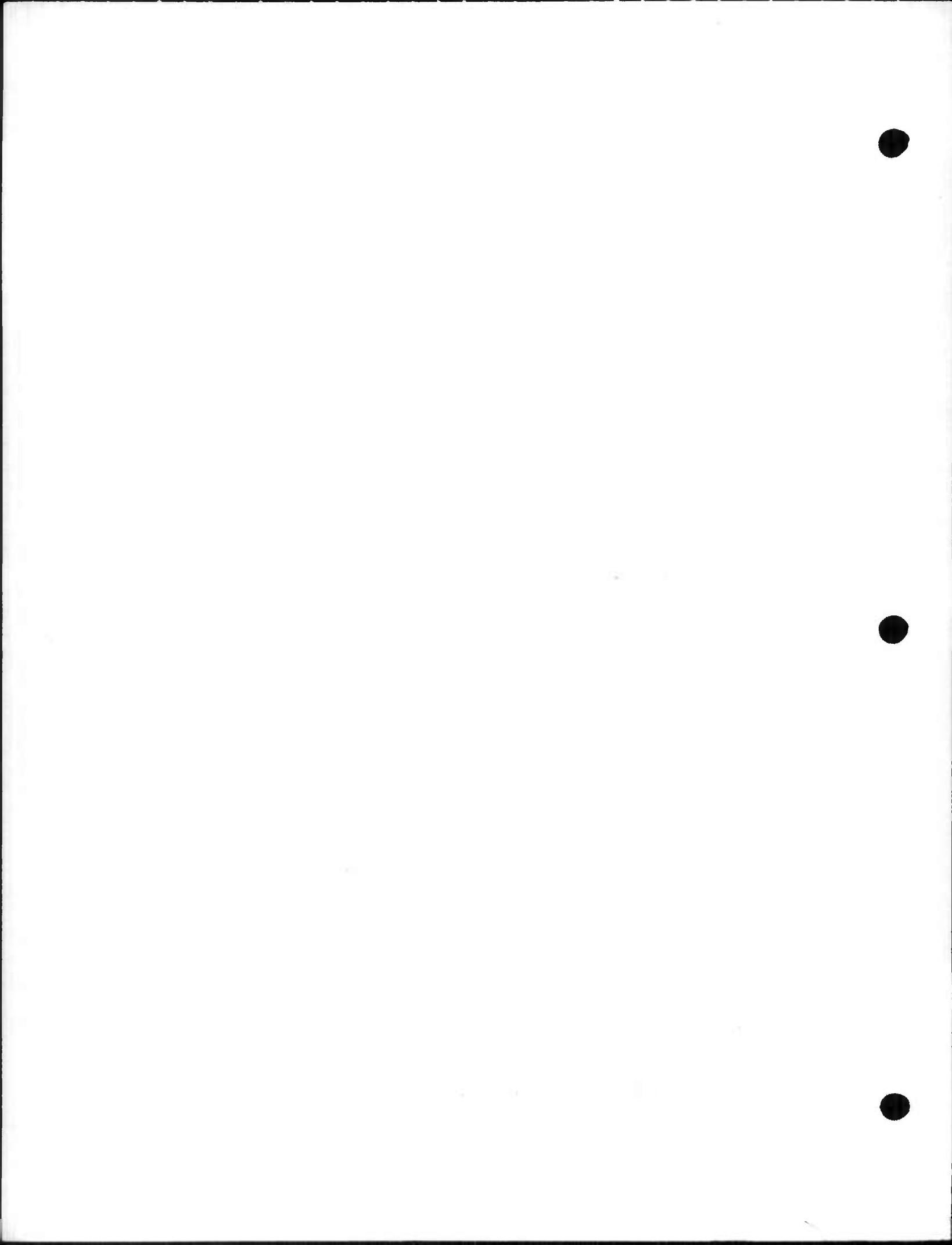
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19075

1. DECEASED'S NAME (First, Middle, Last) Ralph Grayson Kanode Jr				2. DATE OF DEATH MONTH JUNE DAY 10 YEAR 1995	3. TIME OF DEATH 4:55 pm M
4. SOCIAL SECURITY NUMBER 219-14-9448		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.
9a. FACILITY NAME (If not institution, give street and number) 1204 Oakwood Drive		7. DATE OF BIRTH (Month Day Year) Jun 9, 1924			
9b. CITY, TOWN OR LOCATION OF DEATH Frederick		8. BIRTHPLACE (State or Foreign Country) Maryland			
9c. COUNTY OF DEATH Frederick					
RESIDENCE OF DECEASED					
10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
10e. STREET AND NUMBER 1204 Oakwood Drive			10f. ZIP CODE 21701		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2/12/1943-1/27/1946		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Biological Research Ass't		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Ralph Grayson Kanode Sr			18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Rebecca O'Bryan		
19a. INFORMANT'S NAME (Type/Print) Betty J. Kanode			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 106 East Church Street, Frederick, Maryland 21701		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) Mt. Olivet Cemetery Jun 14, 1995		DATE Jun 14, 1995	20c. LOCATION — City or Town, State Frederick, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sherman Kahan			22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church St., Frederick, MD 21701		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOMYOPATHY					
Approximate Interval Between Onset and Death YEARS					
s. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) At home			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D12697			
29b. SIGNATURE AND TITLE OF CERTIFIER Sherman Kahan		29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Sherman Kahan, M.D., 915 Toll House Avenue, Frederick, Maryland 21701					
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE [Signature]			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										3. TIME OF DEATH HRS. MIN.
1. DECEASED'S NAME (First, Middle, Last) ELLEN T. KING		7. DATE OF BIRTH (Month, Day, Year) Dec. 5, 1922										8. BIRTHPLACE (State or Foreign Country) Washington, D.C.
4. SOCIAL SECURITY NUMBER 578-26-1365		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.				
8a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville										9c. COUNTY OF DEATH Montgomery
RESIDENCE OF DECEASED												
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Germantown									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 13135 Dairymaid Dr., Apt. T 1		10f. ZIP CODE 20874									10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Administrative Aide				16b. KIND OF BUSINESS/INDUSTRY U.S. Government						
17. FATHER'S NAME (First, Middle, Last) Harold Compton King						18. MOTHER'S NAME (First, Middle, Maiden Surname) Eugenia Todhunter						
19e. INFORMANT'S NAME (Type/Print) Stephen T. King						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10905 Show Pony Pl., Damascus, Md. 20872						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				20c. LOCATION — City or Town, State Bethesda, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Olin L. Molesworth						22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A. 26401 Ridge Rd., Damascus, Md. 20872						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HYPERTENSIVE CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____												
Approximate Interval Between Onset and Death Years												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {												
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES, DEMENTIA, Renal Insufficiency												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> 4 <input type="checkbox"/> Homicide <input type="checkbox"/> 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
30. SIGNATURE AND TITLE OF CERTIFIER D.L. Green Jr.		30c. LICENSE NUMBER D42710			30d. DATE SIGNED (Month, Day, Year) JUNE 10 1995							
31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DL. GREEN JR 15225 SHADY GROVE ROAD ROCKVILLE, MARYLAND												
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE Jeanne Shuler Harrell										

1968-02-10

1968-02-

January 20th 1968

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95 19077

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) JOSEPH E ugene KENNEDY						2. DATE OF DEATH MONTH DAY YEAR JUNE 08, 1995	3. TIME OF DEATH 21:41 P M
4. SOCIAL SECURITY NUMBER 220-58-3111		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) Oct. 16, 1952	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) SHOCK TRAUMA UNIT				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO	
10e. STREET AND NUMBER 8340 Reich's Ford Road				10f. ZIP CODE 21701			10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES Oct. 28, 1969-Oct. 27, 1975			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver			16b. KIND OF BUSINESS/INDUSTRY General Hauling		
17. FATHER'S NAME (First, Middle, Last) William Arthur Kennedy, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Louise Graser			
19a. INFORMANT'S NAME (Type/Print) Mrs. Donna J. Kennedy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8340 Reich's Ford Road, Frederick, Md. 21701			
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Gardens, June 12, 1995			DATE	20c. LOCATION — City or Town, State Frederick, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kelli Robs							
M00255							
22. NAME AND ADDRESS OF FACILITY Keeney and Basford P.A. Funeral Home 106 East Church St., Frederick, Md. 21701							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE INJURIES DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 □ NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
27. MANNER OF DEATH 1 □ Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 7 □ Determined 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year) 6 8 95		28b. TIME OF INJURY 1806 PM	28c. INJURY AT WORK? 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURRED PEDESTRIAN STRUCK BY VEHICLE	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Roadway		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) RT 29 BETHESDA, MD 20814					
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Josephine Anne Kelly				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) JUNE 09, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Josephine A. Kelly 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE John Dawson Redell					

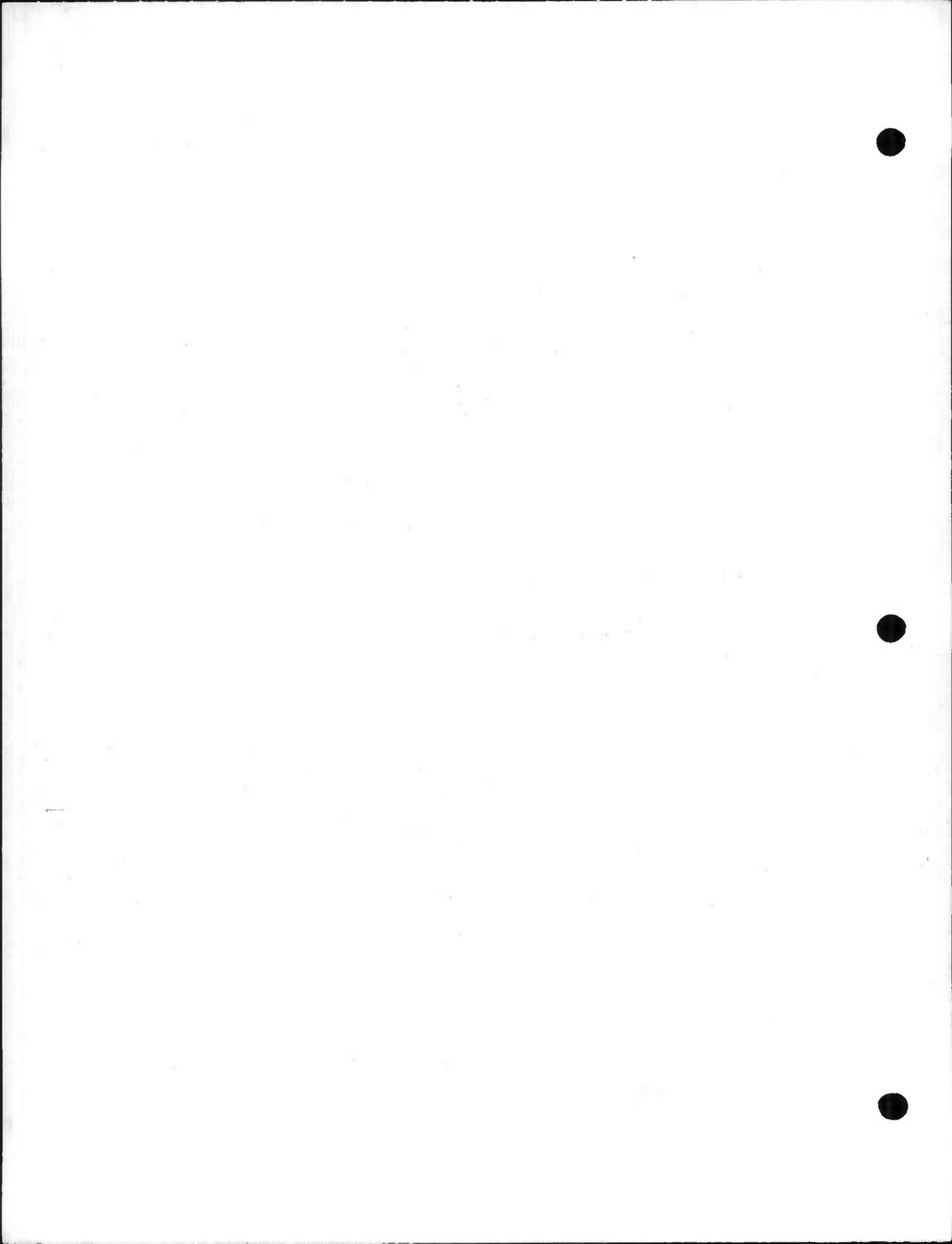
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 68760



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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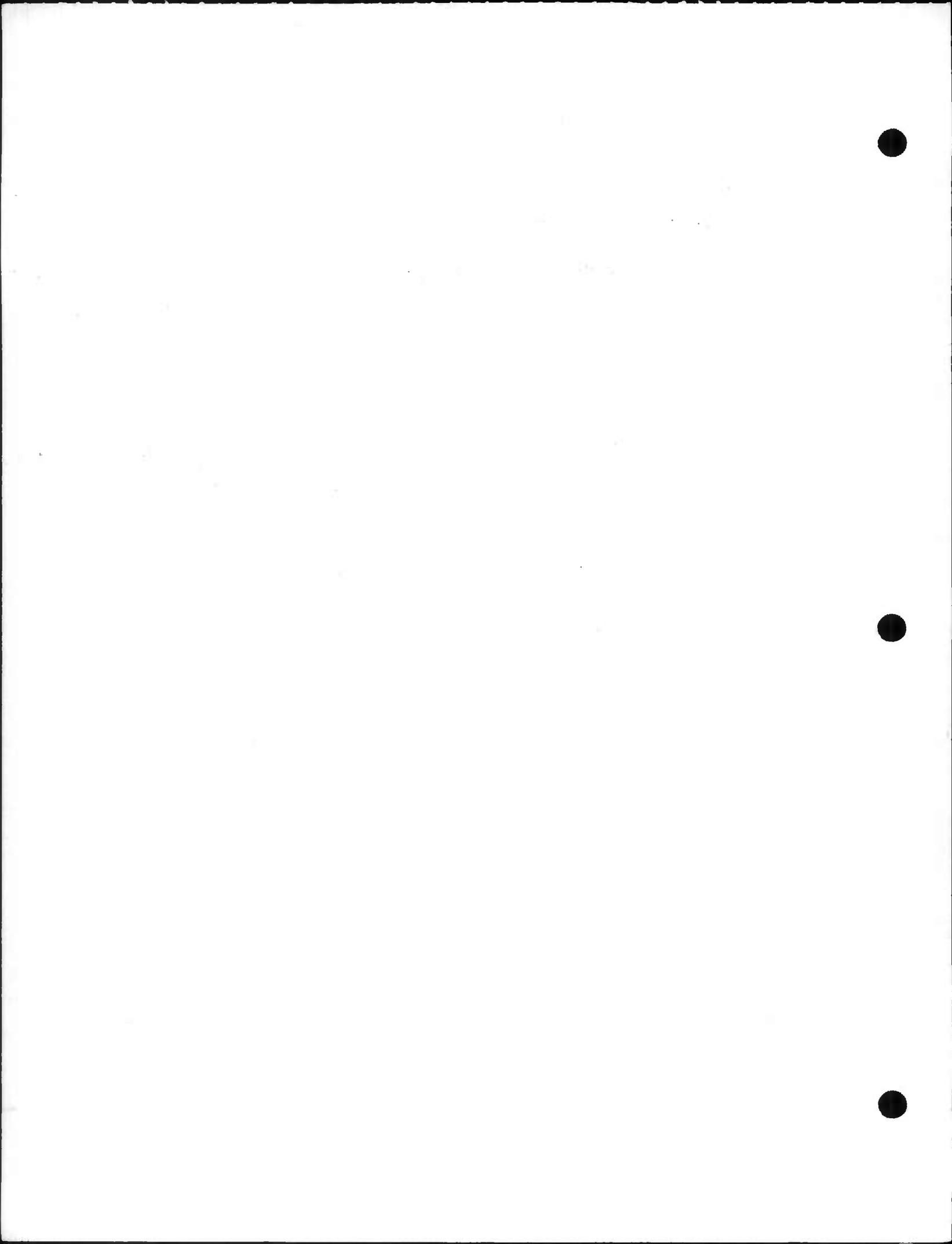
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR REGISTER		2. DATE OF DEATH MONTH June DAY 4 YEAR 1995								3. TIME OF DEATH 9:14A M	
1. DECEDENT'S NAME (First, Middle, Last) William Lee Kimmel										7. DATE OF BIRTH (Month, Day, Year) January 23, 38	
4. SOCIAL SECURITY NUMBER 219-34-5050		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. HOURS 0		MIN. 0		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
RESIDENCE OF DECEDENT 10e. STATE Maryland 10b. COUNTY Frederick 10c. CITY, TOWN OR LOCATION Frederick										10d. INSIDE CITY LIMITS? 1 F YES 2 X NO	
10e. STREET AND NUMBER 11810 Old Annapolis Rd.										10f. ZIP CODE 21701	10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS 1 F Never Married 2 X Married 3 F Widowed 4 F Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? T X YES 2 F NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 F YES 2 X NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)				16b. KIND OF BUSINESS/INDUSTRY Communications Manager				16. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Elizabeth Rippeon	
17. FATHER'S NAME (First, Middle, Last) William W. Kimmel										19a. INFORMANT'S NAME (Type/Print) Loretta J. Kimmel	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11810 Old Annapolis Rd./ Frederick, Md. 21701										20a. METHOD OF DISPOSITION 1 X Burial 2 F Cremation 3 F Removal from State 4 F Donation 5 F Other (Specify)	
20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Central Cemetery Fred. Co. 6-8										DATE Libertytown, Maryland	20c. LOCATION — City or Town, State Stauffer Funeral Home
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY 8 E. Ridgeville Blvd./ Mt. Airy, Md. 21771	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertrophic Cardiomyopathy</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>										Approximate Interval Between Onset and Death 14 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □										24a. WAS AN AUTOPSY PERFORMED? 1 F YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 F YES 2 X NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 F YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 F Inpatient 2 X ER/Outpatient 3 F DOA OTHER: 4 F Nursing Home 5 F Residence 6 F Other (Specify)									
27. MANNER OF DEATH 1 X Natural 2 F Accident 3 F Suicide 4 F Homicide		28a. DATE OF INJURY (Month, Day, Year) 5 F Pending investigation 6 F Could not be determined		28b. TIME OF INJURY M 1 F YES 2 F ND	28c. INJURY AT WORK? 1 F YES 2 F ND	28d. DESCRIBE HOW INJURY OCCURED					
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 F MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Kusay BARAKAT								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 310 w. 9th street Frederick MD 21701	
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE 								29d. DATE SIGNED (Month, Day, Year) ► 6/4/95	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

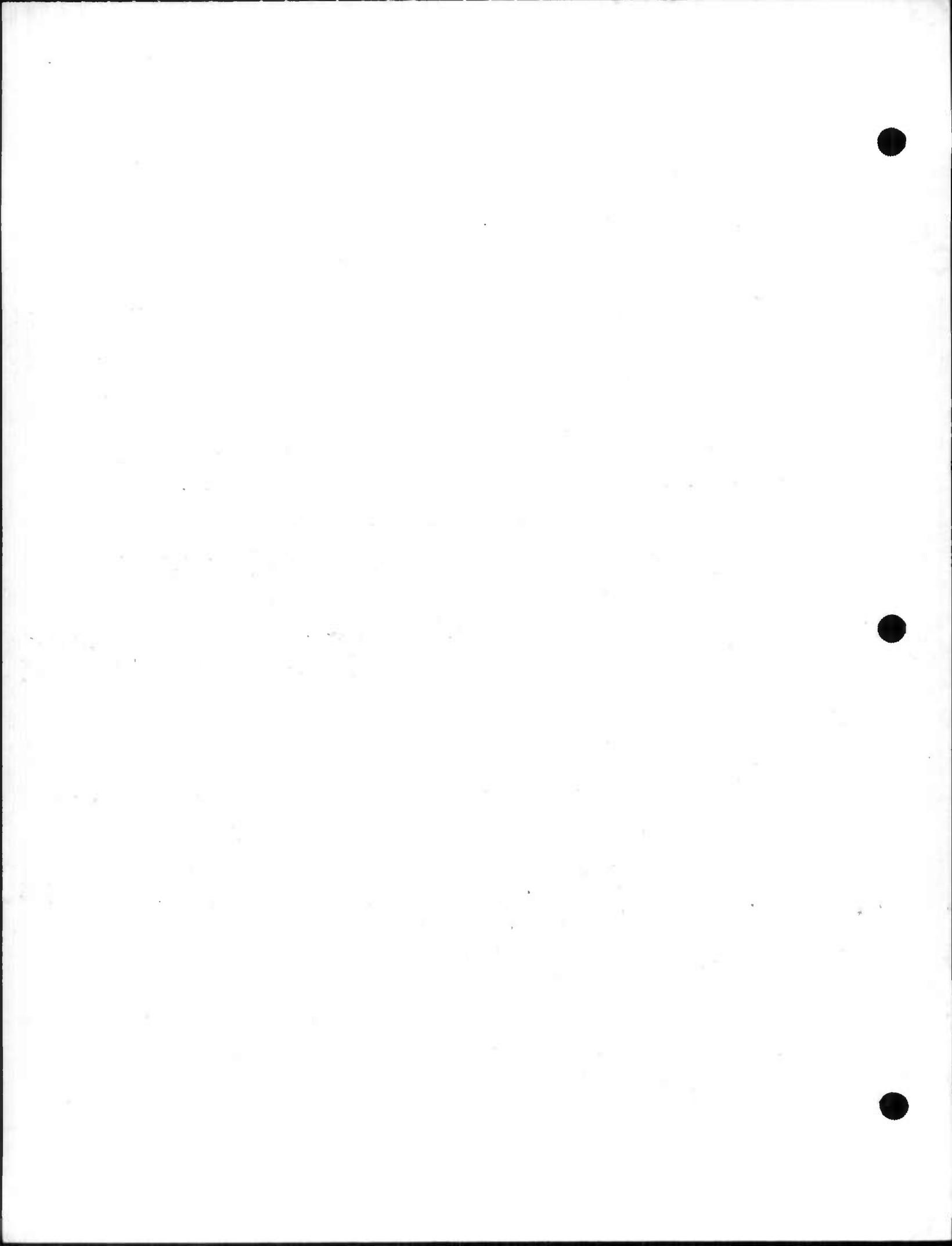
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19079

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH JUNE DAY 04 YEAR 1951 2010 PM				3. TIME OF DEATH		
Fred E. King									
4. SOCIAL SECURITY NUMBER 218-05-0867		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS HOURS MIN.					
9a. FACILITY NAME (If not Institution, give street and number) Shady Grove Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT									
10a. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Mount Airy				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 4413 Highboro Drive			10f. ZIP CODE 21771			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Conductor			16b. KIND OF BUSINESS/INDUSTRY Rail Road				
17. FATHER'S NAME (First, Middle, Last) Elmer F. King					18. MOTHER'S NAME (First, Middle, Maiden Surname) Goldie Myers				
19a. INFORMANT'S NAME (Type/Print) Marian E. King			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4413 Highboro Drive, Mount Airy, Maryland 21771						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Carmel Cemetery			DATE 6/7	20c. LOCATION — City or Town, State Littlestown, Penna.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Olin L. Molesworth			22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Border Artery Thrombosis</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Insulin Dependent Diabetes Mellitus</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i></p>									
<p>Approximate Interval Between Onset and Death 3 days</p> <p>20 years</p>									
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
<i>Ischaemic Cardiopathy</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER John M. G. King, M.D.			29c. LICENSE NUMBER D35192			29d. DATE SIGNED (Month, Day, Year) ► 5 Jun 95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kovin M. G. King, M.D. 10001 Dupont Street Washington, DC 20028									
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE John M. G. King, M.D.							



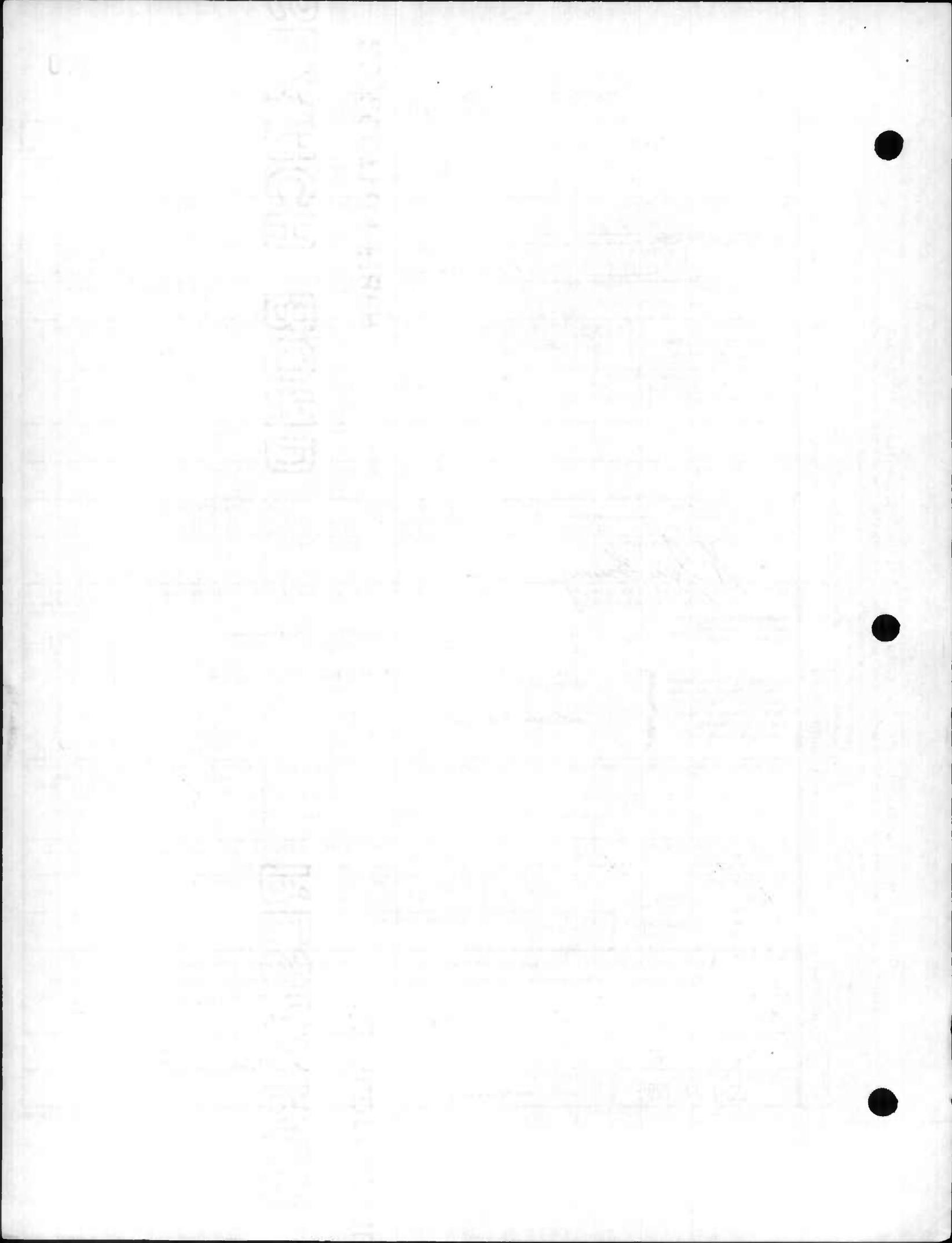
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

AMENDED #10a, 10b, 10c, 10e, 10f, 6/8/95, B.P., WORCESTER CO.												95 19080		
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH														
REG. NO.														
1. DECEDENT'S NAME (First, Middle, Last) <i>JAMES JOSEPH KAY</i>												2. DATE OF DEATH		3. TIME OF DEATH
FOR STATE REGISTRAR				MONTH		DAY		YEAR						
				6		6		95		2320				
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)		
184-09-7078		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		90 YRS.		MONTHS		DAYS		MONTH, DAY, YEAR		PA		
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH		
Atlantic General Hospital										Berlin		Worcester		
RESIDENCE OF DECEDENT														
10a. STATE		10b. COUNTY				10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?		
VA. MD.		Fairfax		WORCESTER		Fairfax		BERLIN				<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER				9715 HEALTHWAY DRIVE						22030-21611		10g. CITIZEN OF WHAT COUNTRY?		
-9229-Arlington Blvd.				BERLIN NURSING home								USA		
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		unknown								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		
15. DECEDENT'S EDUCATION (Specify only highest grade completed)						16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)						16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12)		College (1-4 or 5+)				Electrician						Electrical Contractor		
17. FATHER'S NAME (First, Middle, Last)												18. MOTHER'S NAME (First, Middle, Maiden Surname)		
Jacob Cohen												Dora (unknown)		
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Patricia Foley				25 Coastal Dr. Berlin, MD 21811										
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				National Memorial Park				6/9/95		Falls Church, VA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY										
<i>J. J. Burt</i>				Burbage Funeral Home 108 Williams st. Berlin, MD 21811										
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
Approximate Interval Between Onset and Death														
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>MYOCARDIAL INFARCTION</i> 1 DAY <small>DUE TO (OR AS A CONSEQUENCE OF):</small> b. <i>INSULIN DEP. DIABETES MELLITUS</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> c. _____ <small>DUE TO (OR AS A CONSEQUENCE OF):</small> d. _____														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO														
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO														
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)										
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED				
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				5 <input type="checkbox"/> Pending Investigation a <input type="checkbox"/> Could not be determined		4 <input type="checkbox"/> Nursing Home		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						
29a. CERTIFIER				1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)								
<i>James Joseph Kay</i>				D46257		6/7/95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
7187 Bent Pine Rd. WILLOWS, MD 21874														
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE										
JUN 08 1995				<i>John S. Johnson-Randall</i>										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

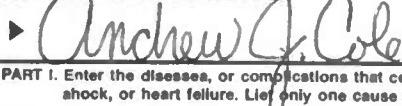
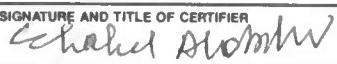
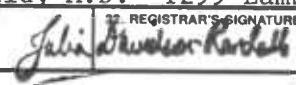
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

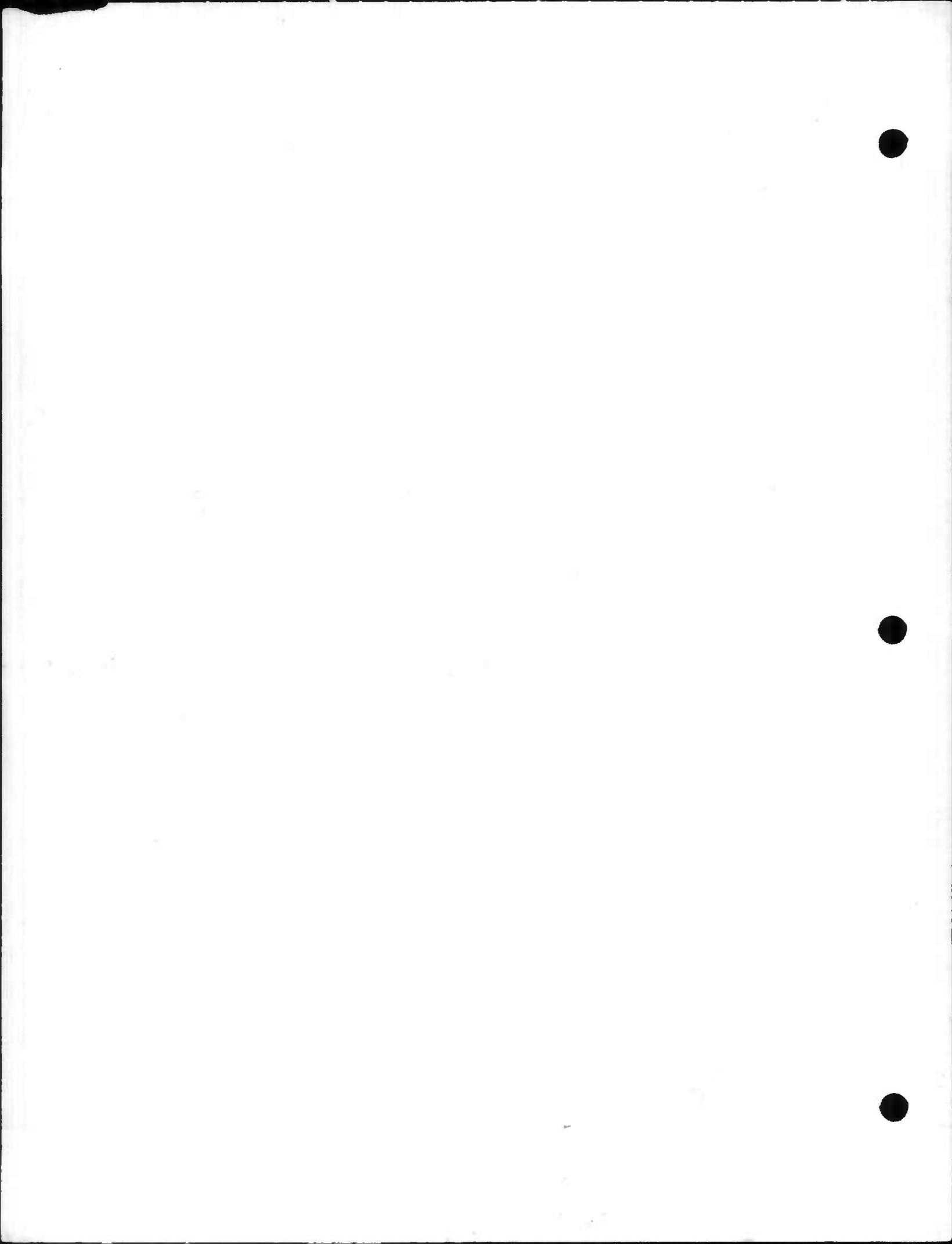
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR														
1. DECEDENT'S NAME (First, Middle, Last)													2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Marion Erhardt Liewald													June 7, 1995	9:00 PM
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
579-28-6174		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		90 YRS.		MONTHS		DAYS		HOURS		April 28, 1905	Washington, D.C.	
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH		
1906 Alberti Drive						Wheaton						Montgomery		
RESIDENCE OF DECEDENT														
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Maryland		Montgomery		Wheaton										
10e. STREET AND NUMBER						10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?		
1906 Alberti Drive						20902						U.S.A.		
11. MARITAL STATUS			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify:					
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced									White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 12				Homemaker					Own Home					
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)								
John Harry Erhardt						Mary Jane Barr								
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Wilda W. Landolt						1615 Moffet Road Silver Spring, Maryland 20903								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. LOCATION — City or Town, State							
				George Washington Cemetery			6/12/95			Adelphi, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) →														
a. Dementia DUE TO (OR AS A CONSEQUENCE OF):														
b. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
Approximate Interval Between Onset and Death Many Yrs.														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D43496		29d. DATE SIGNED (Month, Day, Year) ► 6-8-95										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
Mohammad Khalid, M.D. 1299 Lamberton Drive Silver Spring, Maryland 20902														
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 												



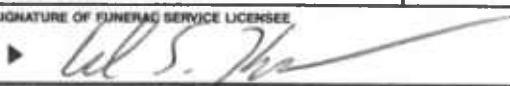
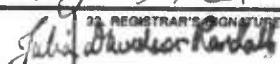
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that at the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

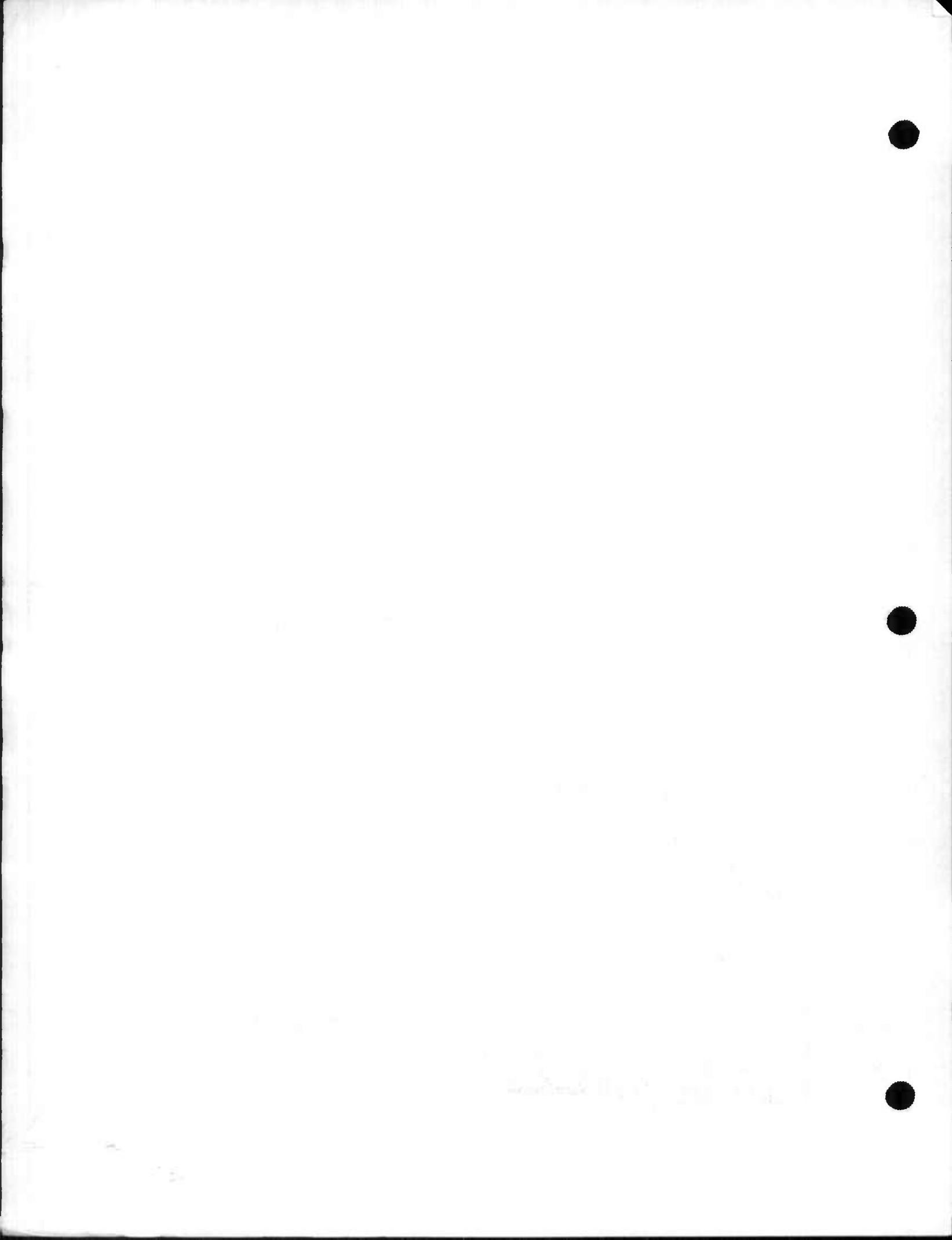
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.						
		1. DECEDENT'S NAME (First, Middle, Last) Sun Yea Lee					2. DATE OF DEATH MONTH JUNE DAY 7 YEAR 1995		3. TIME OF DEATH 7:15 P M						
		4. SOCIAL SECURITY NUMBER 220-86-3070		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 20, 1921					
		8a. FACILITY NAME (If not institution, give street and number) Arcola Rehabilitation/Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring					9c. COUNTY OF DEATH Montgomery						
		RESIDENCE OF DECEDENT													
		10a. STATE Maryland		10b. COUNTY Montgomery			10c. CITY, TOWN OR LOCATION Silver Spring			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
		10e. STREET AND NUMBER 14535 Cutstone Way				10f. ZIP CODE 20905			10g. CITIZEN OF WHAT COUNTRY? Korea						
		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Korean					
		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home								
		17. FATHER'S NAME (First, Middle, Last) Yoon Man Bong				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kum Yea Lee									
		19a. INFORMANT'S NAME (Type/Print) Jong Il Lee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14535 Cutstone Way, Silver Spring, Maryland 20905									
		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Norbeck Memorial Park			DATE 6/10		20c. LOCATION — City or Town, State Olney, Maryland						
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904									
		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 1 day 5 years			
		IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. DUE TO (OR AS A CONSEQUENCE OF): Congestive Heart Failure											
				b. DUE TO (OR AS A CONSEQUENCE OF): End Stage Renal Disease											
				c. DUE TO (OR AS A CONSEQUENCE OF):											
				d. DUE TO (OR AS A CONSEQUENCE OF):											
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus with Neuropathy Anemia Hypertension										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D-30929		29d. DATE SIGNED (Month, Day, Year) ► 6/8/95									
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 1104 Spring Street #201, Silver Spring, MD 20910													
		31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

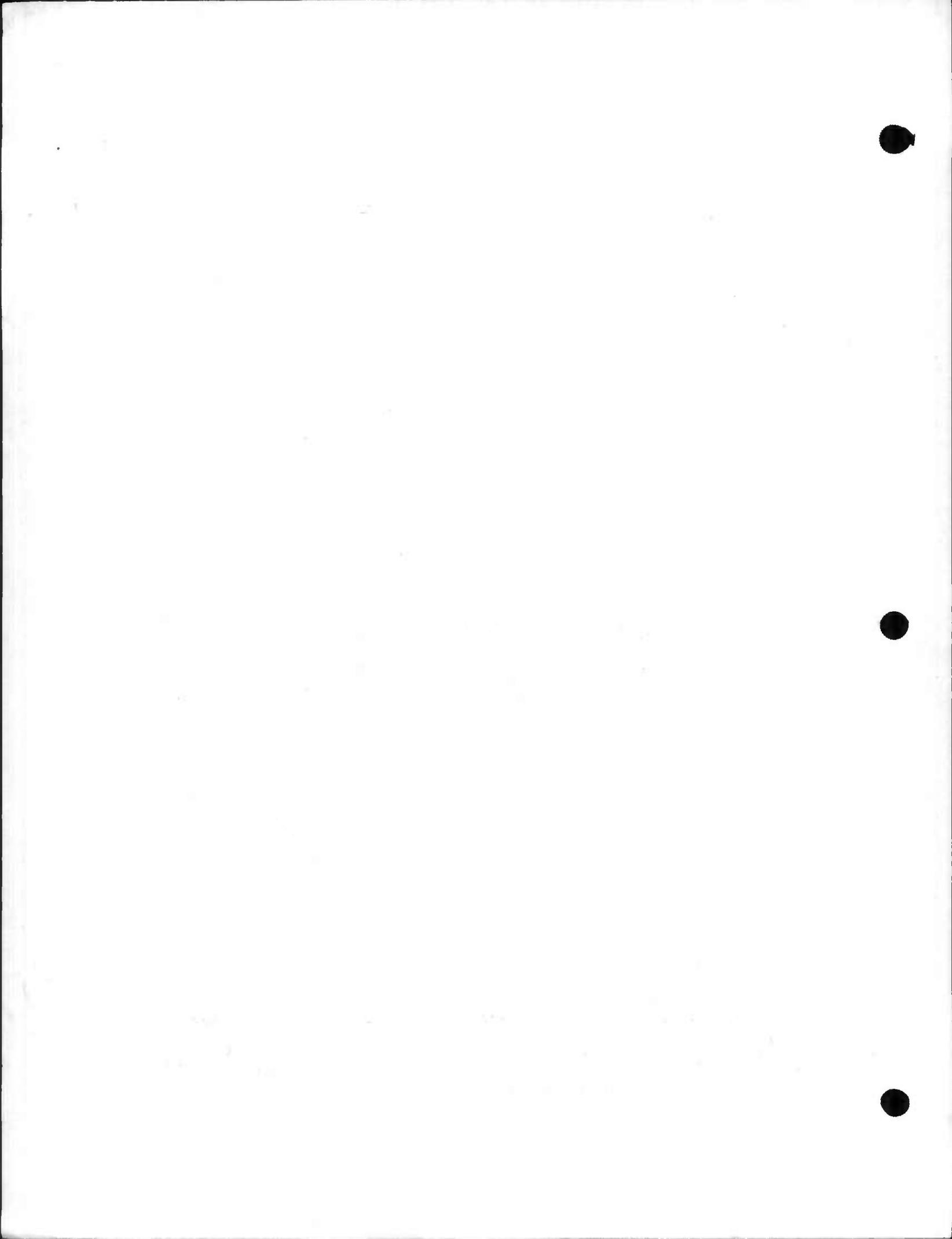
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19083

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH JUNE 4, 1995 DAY YEAR				3. TIME OF DEATH 7:17pm. M							
WILLIAM F. LAWRENCE													
4. SOCIAL SECURITY NUMBER 226-68-1497		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN.			
9a. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH LANHAM-SEABROOK				7. DATE OF BIRTH (Month, Day, Year) Jan. 1, 1931				8. BIRTHPLACE (State or Foreign Country) Ohio			
RESIDENCE OF DECEDENT		10c. CITY, TOWN OR LOCATION College Park				9c. COUNTY OF DEATH PRINCE GEORGE'S CO.				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STATE Maryland		10b. COUNTY Prince George's		10f. ZIP CODE 20741-1049				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+ Health Physicist				16b. KIND OF BUSINESS/INDUSTRY Radiation Safety							
17. FATHER'S NAME (First, Middle, Last) William Lawrence						18. MOTHER'S NAME (First, Middle, Maiden Surname) Esther Rose Bodkin							
19a. INFORMANT'S NAME (Type/Print) Monique Lawrence						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory				DATE 6-6		20c. LOCATION — City or Town, State Beltsville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Eileen S. Rapp						22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arteriosclerotic cardiovascular disease with dissecting thoracic aneurysm</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>due to (or as a consequence of):</i>													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
DUE TO (OR AS A CONSEQUENCE OF): <i>due to (or as a consequence of):</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>due to (or as a consequence of):</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>due to (or as a consequence of):</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				OTHER:							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez MD</i>		29c. LICENSE NUMBER D 212 30				29d. DATE SIGNED (Month, Day, Year) June 5, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cl. Spur. Md 20748</i>		31. REGISTRAR'S SIGNATURE <i>John Shuster-Robell</i>											
31. DATE FILED (Month, Day, Year) JUN 07 1995													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

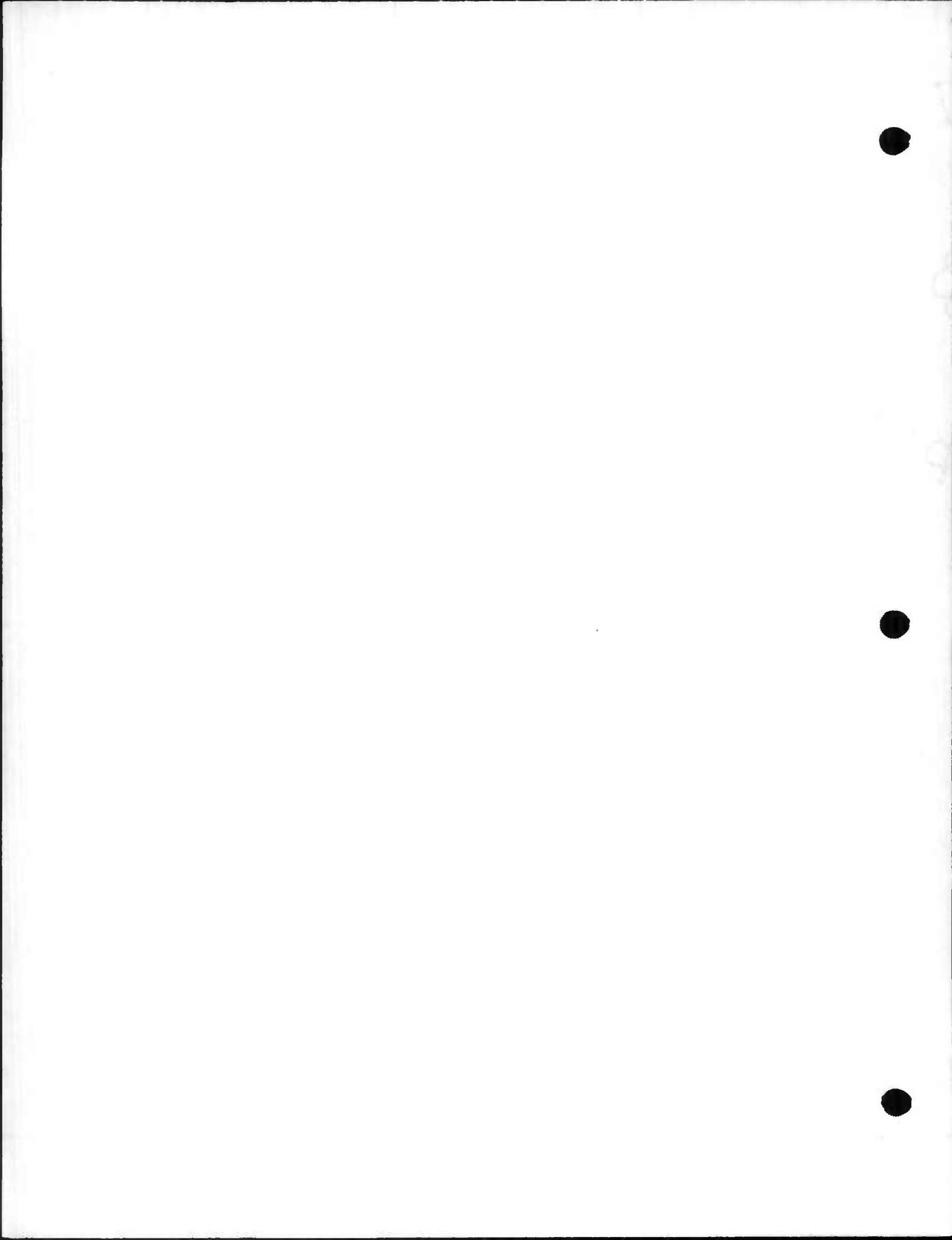
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		Bay Stewart Leber						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 5:17 AM M	
4. SOCIAL SECURITY NUMBER 175-10-0831		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTHN (Month, Day, Year) Aug. 21, 1909		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 3620 Littledale Road		9b. CITY, TOWN OR LOCATION OF DEATHN Kensington						9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEASED											
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Kensington						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3620 Littledale Road				10f. ZIP CODE 20895				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Executive		16b. KIND OF BUSINESS/INDUSTRY Home Improvements							
17. FATHER'S NAME (First, Middle, Last) Edward Leber				19. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Bay Stewart							
19a. INFORMANT'S NAME (Type/Print) Serena S. Leber				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 6-3		20c. LOCATION — City or Town, State Beltsville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Elan H. Rapp</i>				22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):										15 minutes	
b. Cardiac Failure DUE TO (OR AS A CONSEQUENCE OF):										15 minutes	
c. DUE TO (OR AS A CONSEQUENCE OF): d. Bladder cancer										5 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CAB, COPD										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				26a. DATE OF INJURY (Month, Day, Year)	26b. TIME OF INJURY M t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	26c. INJURY AT WORK? M t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	26d. DESCRIBE HOW INJURY OCCURRED				
				26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER D 29685				29d. DATE SIGNED (Month, Day, Year) ► June 2, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Phyllis Brandshaft, M. D., 10810 Connecticut Avenue, Kensington, MD 20895											
31. DATE FILED (Month, Day, Year) JUN 05 1995				32. REGISTRAR'S SIGNATURE <i>Jahn Shuler Redell</i>							



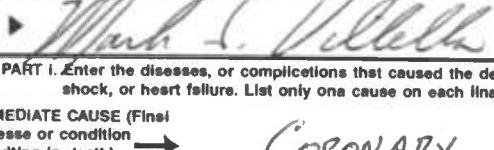
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

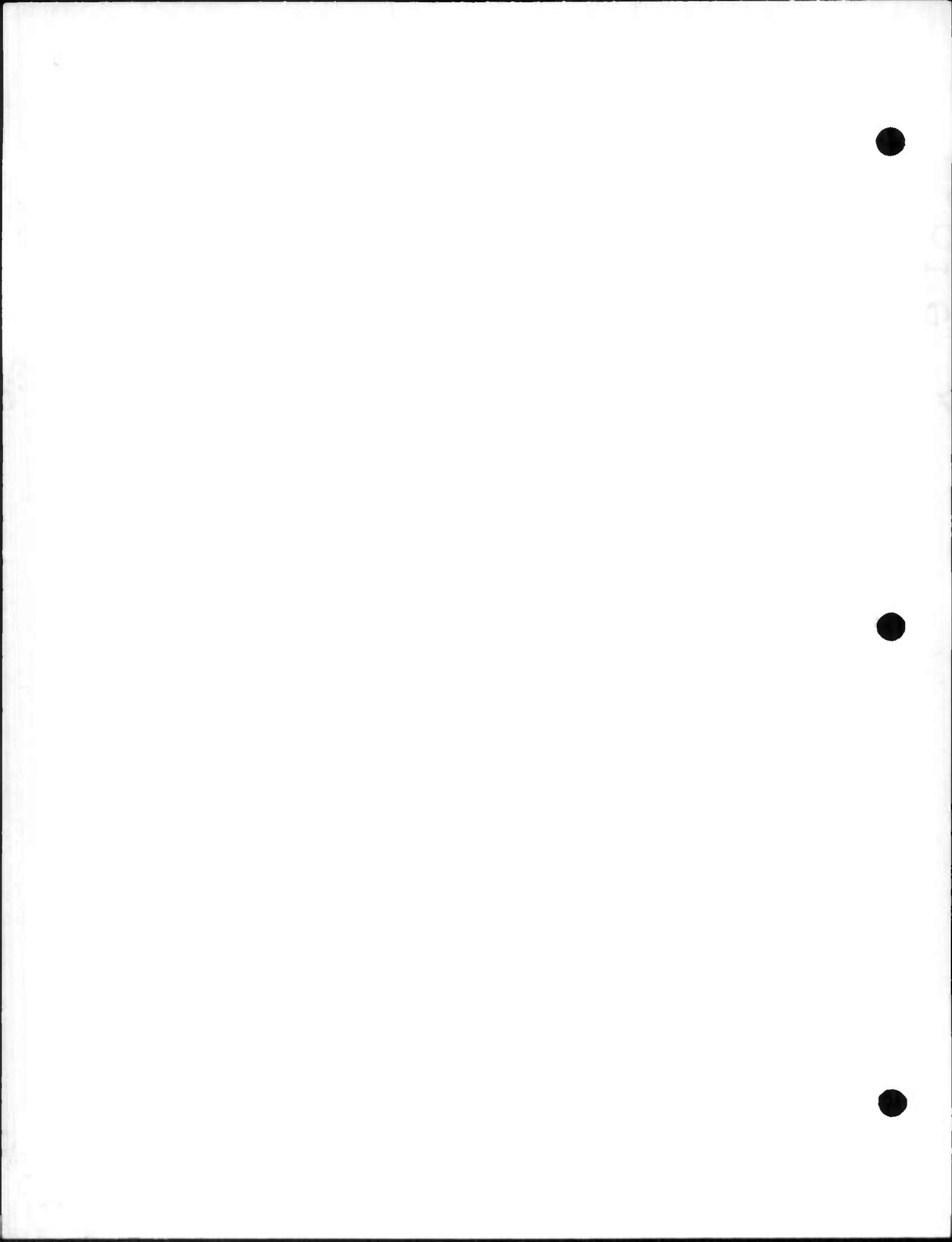
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) William Jerome Lockwood										2. DATE OF DEATH MONTH DAY YEAR June 3, 1995	3. TIME OF DEATH 10:10 AM	
4. SOCIAL SECURITY NUMBER 314-03-5271		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 4, 1915			8. BIRTHPLACE (State or Foreign Country) Indiana	
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Silver Spring								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 10429 Hayes Avenue										10f. ZIP CODE 20902	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1943-1946				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)				16b. KIND OF BUSINESS/INDUSTRY Federal Government						
17. FATHER'S NAME (First, Middle, Last) Pirl Lockwood										18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Hope Hale		
19a. INFORMANT'S NAME (Type/Print) Alberta H. Lockwood										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10429 Hayes Avenue Silver Spring, Maryland 20902		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 6/6/95				DATE	20c. LOCATION — City or Town, State Silver Spring, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death 4 months.		
<p>a. CORONARY Artery Disease DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive Pulmonary Disease Organic Brain Syndrome										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Gregory H. Fisher, MD		29c. LICENSE NUMBER D26443								29d. DATE SIGNED (Month, Day, Year) JUNE 4, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 15225 Shady Grove Road, Rockville, Maryland.												
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

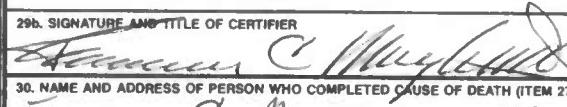
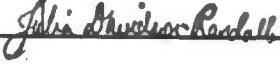
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

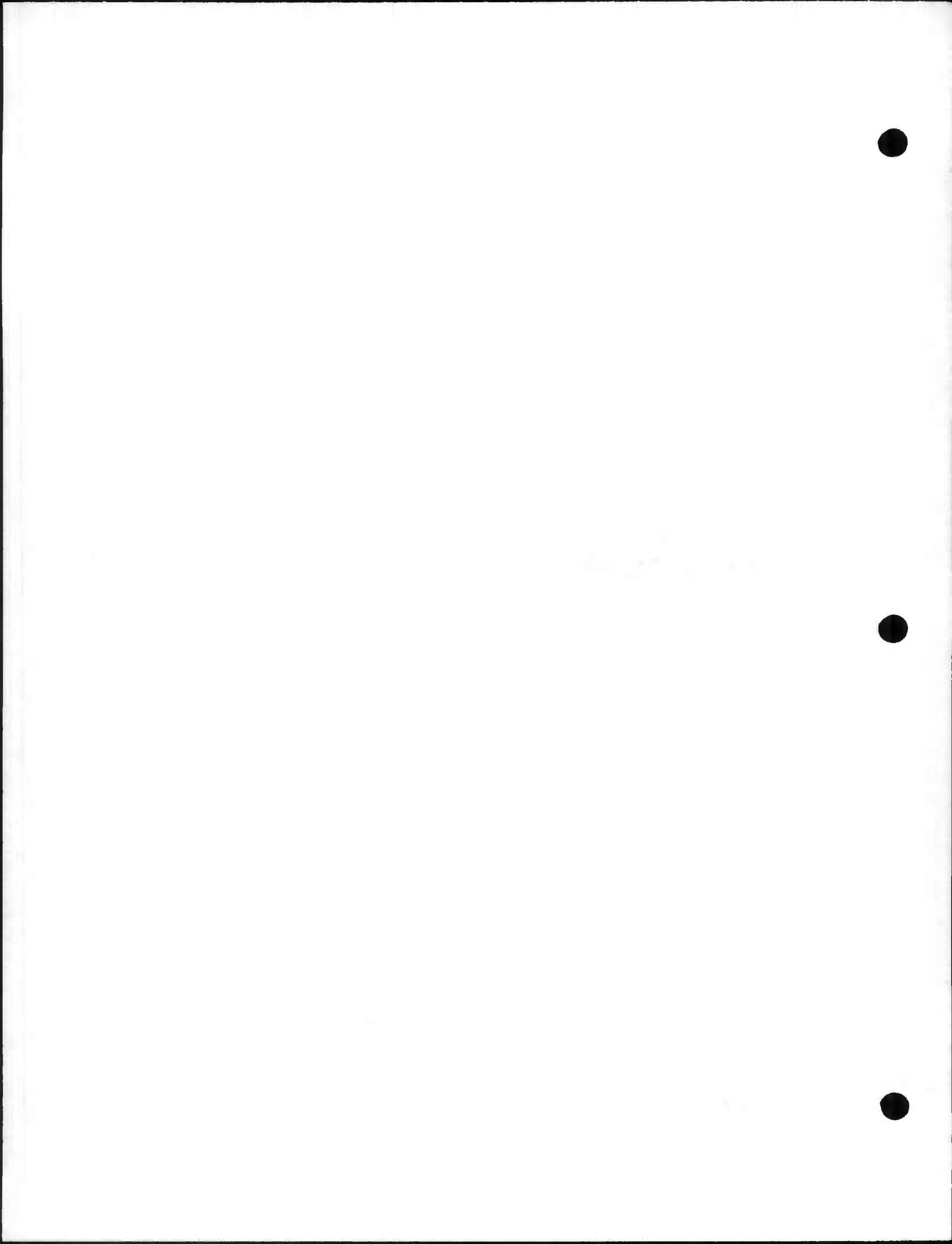
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) LARRY RICHARD LACKEY												2. DATE OF DEATH MONTH DAY YEAR JUNE 6 95	3. TIME OF DEATH 14:00 P M	
4. SOCIAL SECURITY NUMBER 579 42 9644		5. SEX 1 X M 2 F		6. AGE (In yrs. last birthday) 61 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 4, 1933		8. BIRTHPLACE (State or Foreign Country) Pennsylvania				
9a. FACILITY NAME (If not Institution, give street and number) 5617 Madison Street						9b. CITY, TOWN OR LOCATION OF DEATH Bethesda						9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO		
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda						10g. CITIZEN OF WHAT COUNTRY? United States				
10e. STREET AND NUMBER 5617 Madison Street		10f. ZIP CODE 20817						10i. KIND OF BUSINESS/INDUSTRY Brokerage Firm						
11. MARITAL STATUS 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES 1952-1954		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White		14. RACE — American Indian, Black, White, etc.								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Stock Broker		16b. KIND OF BUSINESS/INDUSTRY Brokerage Firm										
17. FATHER'S NAME (First, Middle, Last) Daniel H. Lackey						16. MOTHER'S NAME (First, Middle, Maiden Surname) E. May Enders								
19a. INFORMANT'S NAME (Type/Print) Donald E. Lackey						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14707 Winthrop Drive, Silver Spring, MD 20905								
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 6 □ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) East Harrisburg Cemetery			DATE June 9, 1995			20c. LOCATION — City or Town, State Penbrook, Pennsylvania					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501								
23. PART I. List the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):												ACUTE		
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):												INDEF		
c. _____ DUE TO (OR AS A CONSEQUENCE OF):														
d. _____														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN <input checked="" type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)												
27. MANNER OF DEATH 1 X Natural 5 □ Pending Investigation 2 □ Accident 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ NO		28d. DESCRIBE HOW INJURY OCCURRED						
8 □ Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 007099			29d. DATE SIGNED (Month, Day, Year) JUNE 7 95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C MAYLE 10215 FERNWOOD RD BETHESDA MD 20817														
31. DATE FILED (Month, Day, Year) JUN 08 1995						32. REGISTRAR'S SIGNATURE 								



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

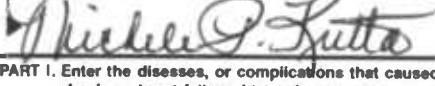
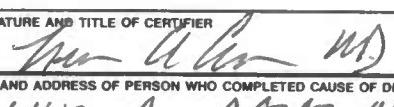
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

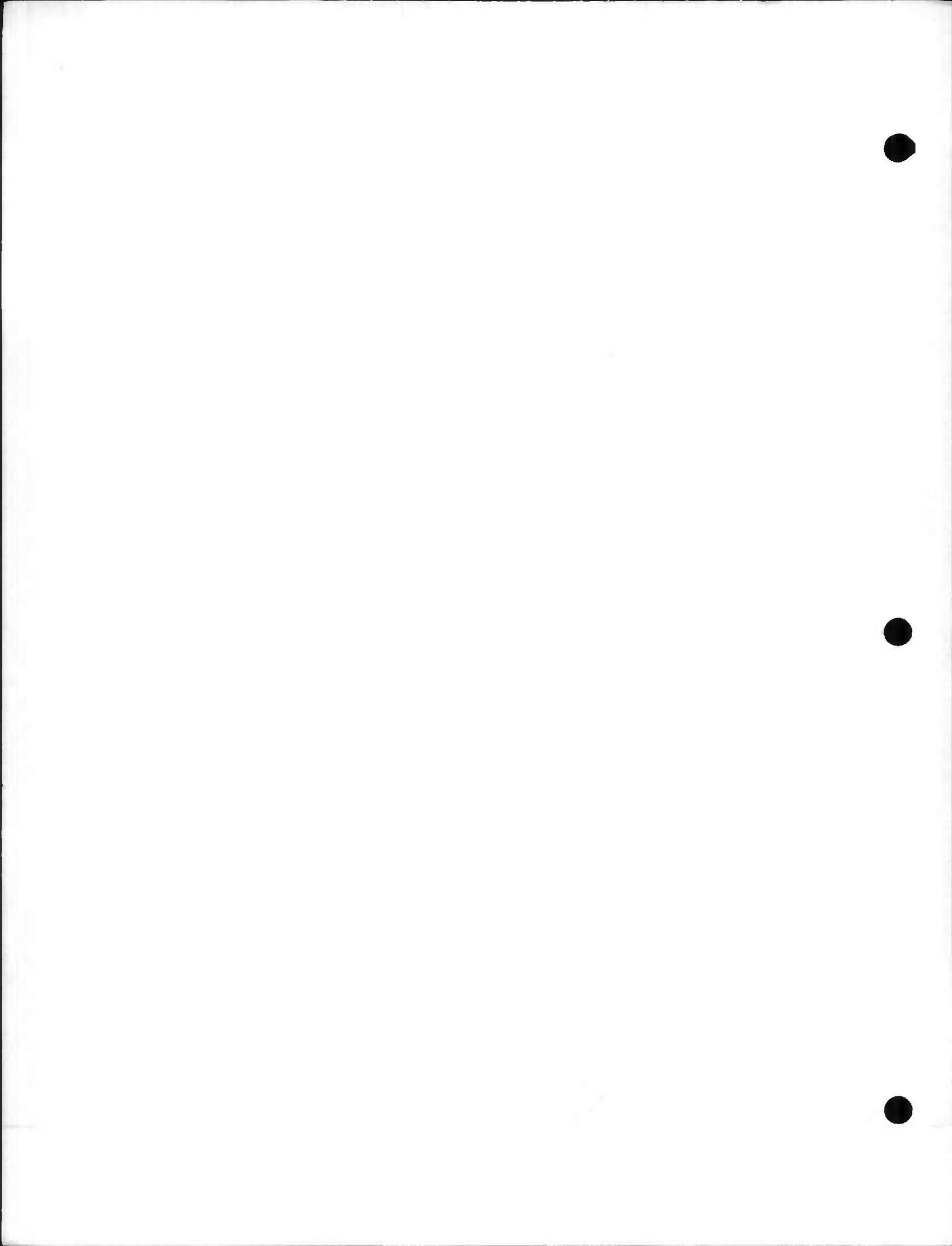
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or if Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Fern Todne Longenecker										2. DATE OF DEATH MONTH DAY YEAR June 4, 1995	3. TIME OF DEATH 1:45 A.M.
4. SOCIAL SECURITY NUMBER 393-18-2548		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct. 20, 1922		8. BIRTHPLACE (State or Foreign Country) Ohio			
9a. FACILITY NAME (If not institution, give street and number) Hillhaven Nursing Center										9b. CITY, TOWN OR LOCATION OF DEATH Adelphi	9c. COUNTY OF DEATH Prince George's
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Silver Spring								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1331 Hornell Drive										10f. ZIP CODE 20905	10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) College (1-4 or 5+) Secretary								16b. KIND OF BUSINESS/INDUSTRY Executive	
17. FATHER'S NAME (First, Middle, Last) Charles White Longenecker										18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Lose	
19a. INFORMANT'S NAME (Type/Print) Perry A. Lester					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12619 Meadowood Drive, Silver Spring, MD 20904						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) June 7, 1995								20c. LOCATION — City or Town, State Parklawn Memorial Park Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death	
a. SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF):											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER DZ4997	29d. DATE SIGNED (Month/Day, Year) ► 6/4/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Luis A. Casas MD 8317 Cherry Lane Laurel MD 20707											
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE 									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

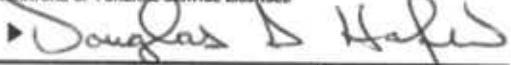
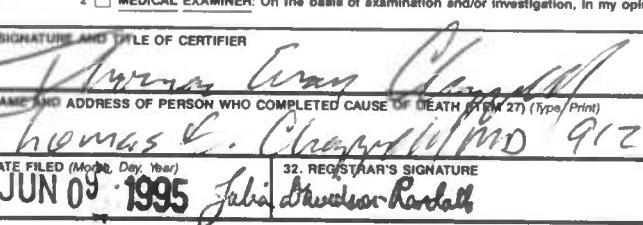
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

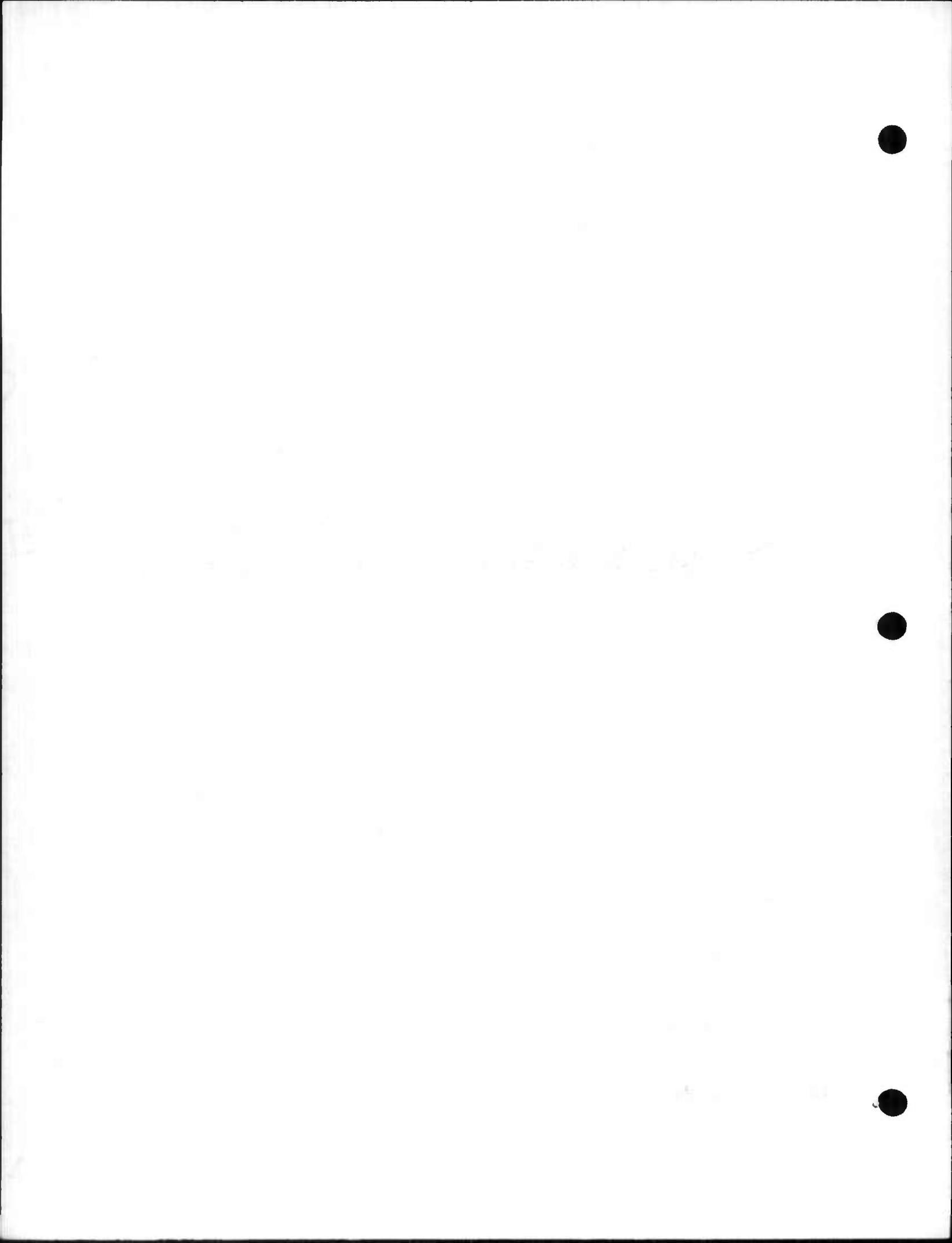
95 19088

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
CHARLES ALBERT LIST						JUNE 6, 1995	2128 P.M.
4. SOCIAL SECURITY NUMBER 232-07-2942		5. SEX M	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MARCH 30 1912	8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND	
RESIDENCE OF DECEDENT						9c. COUNTY OF DEATH ALLEGANY	
10a. STATE MARYLAND	10b. COUNTY ALLEGANY	10c. CITY, TOWN OR LOCATION CUMBERLAND				10d. INSIDE CITY LIMITS? X YES 2 NO	
10e. STREET AND NUMBER 769 FAYETTE STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4		16b. KIND OF BUSINESS/INDUSTRY PROJECT ENGINEER		16c. KIN OF BUSINESS/INDUSTRY FIBER/TEXTILE	
17. FATHER'S NAME (First, Middle, Last) CLAUDE E. LIST				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARA A. SHERRER			
19a. INFORMANT'S NAME (Type/Print) ISABEL V. LIST				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 769 FAYETTE STREET CUMBERLAND, MD 21502			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SMITHSBURG CREMATORIAL 6/7		20c. DATE		20c. LOCATION — City or Town, State SMITHSBURG, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY KIGHT FUNERAL HOME 309-311 DECATUR STREET CUMBERLAND, MD 21502			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Colon Cancer</i> (Due to or as a consequence of) b. _____ (Due to or as a consequence of) c. _____ (Due to or as a consequence of) d. _____ (Due to or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER MD 35735		29d. DATE SIGNED (Month, Day, Year) JUNE 7 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) Thomas E. Chappell, MD 912 Seton Dr. Cumberland, MD							
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE Julia Shuler-Randall					

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

25



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

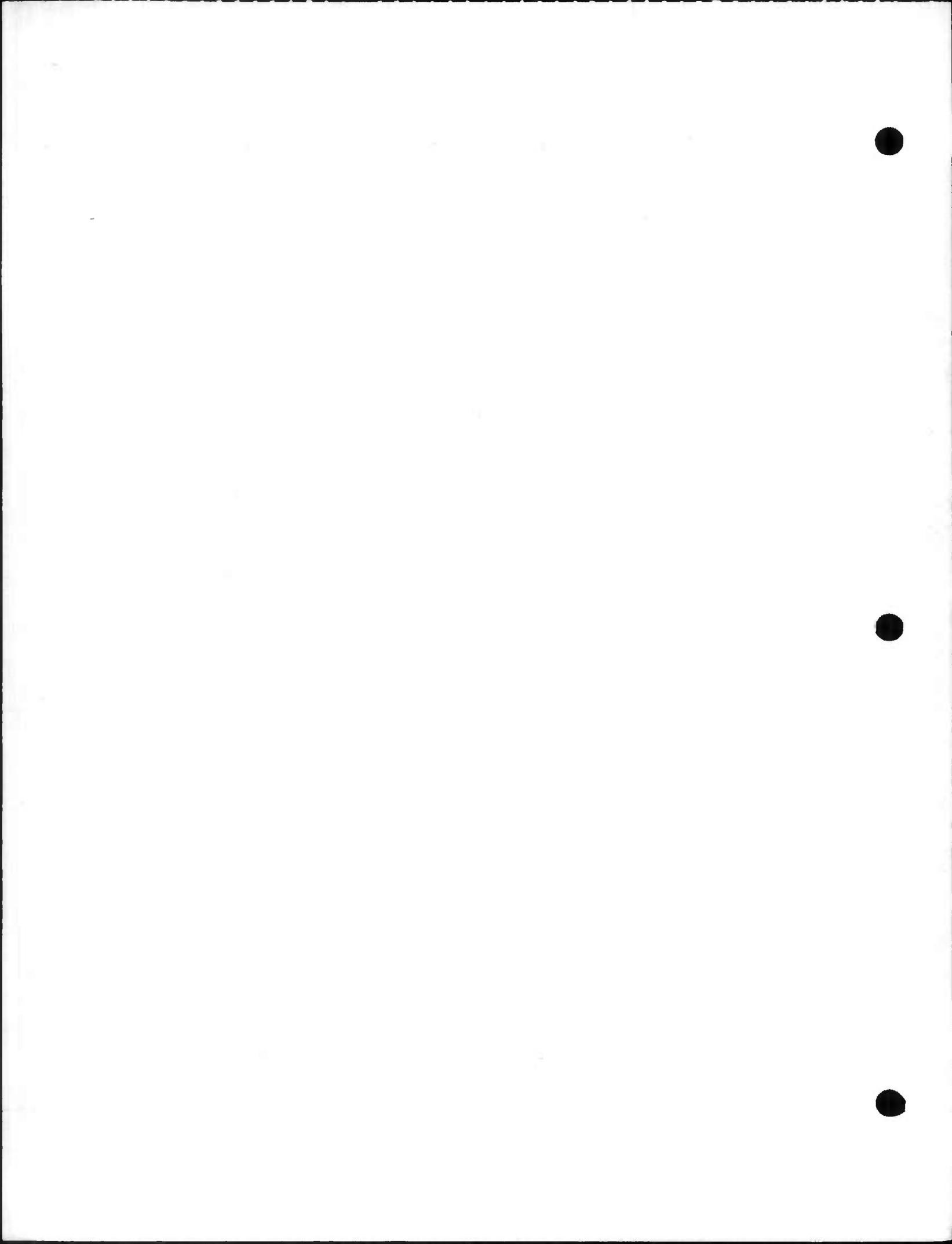
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19089

1. DECEDENT'S NAME (First, Middle, Last) VALENTINE JOSEPH LYDINGER						2. DATE OF DEATH MONTH DAY YEAR JUNE 6, 1995	3. TIME OF DEATH 9:25 P M		
4. SOCIAL SECURITY NUMBER 214 05 6902		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 MONTHS 0 DAYS 0 HOURS 0 MIN.	7. DATE OF BIRTH (Month, Day, Year) Jul 22, 1911	8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY			
RESIDENCE OF DECEDENT									
10a. STATE MD	10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? X YES 2 □ NO		
10e. STREET AND NUMBER 707 Maryland Avenue				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES 			13. WAS DECEDENT OF NISPAHIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: 			14. RACE — American Indian, Black, White, etc. white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Route Salesman			16b. KIND OF BUSINESS/INDUSTRY Meat Packing Co.			16c. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche (Holsinger)	
17. FATNER'S NAME (First, Middle, Last) Joseph J. Lydinger				19a. INFORMANT'S NAME (Type/Print) Bertha M. Lydinger					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 707 Maryland Avenue; Cumberland, MD 21502
20a. METHOD OF DISPOSITION 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cumberland Crematory			DATE 06/07		20c. LOCATION — City or Town, State Cumberland, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James T. Scappelli				22. NAME AND ADDRESS OF FACILITY Scappelli Funeral Home Cumberland, MD 21502					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure								1 yr.	
b. DUE TO (OR AS A CONSEQUENCE OF): Renal Failure								3 yrs.	
c. DUE TO (OR AS A CONSEQUENCE OF): 									
d. DUE TO (OR AS A CONSEQUENCE OF): 									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 								24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO X UNCERTAIN □									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 X DOA OTHER: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)							
27. MANNER OF DEATH 1 X Natural 5 □ Pending investigation 2 □ Accident 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ ND		28d. DESCRIBE HOW INJURY OCCURRED 	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State) 	
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Thomas E. Chappel		29c. LICENSE NUMBER MD 35735		29d. DATE SIGNED (Month, Day, Year) 6/7/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. THOMAS CHAPPEL/912 SETON DRIVE/CUMBERLAND, MD. 21502									
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE Julin Dawson-Randall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

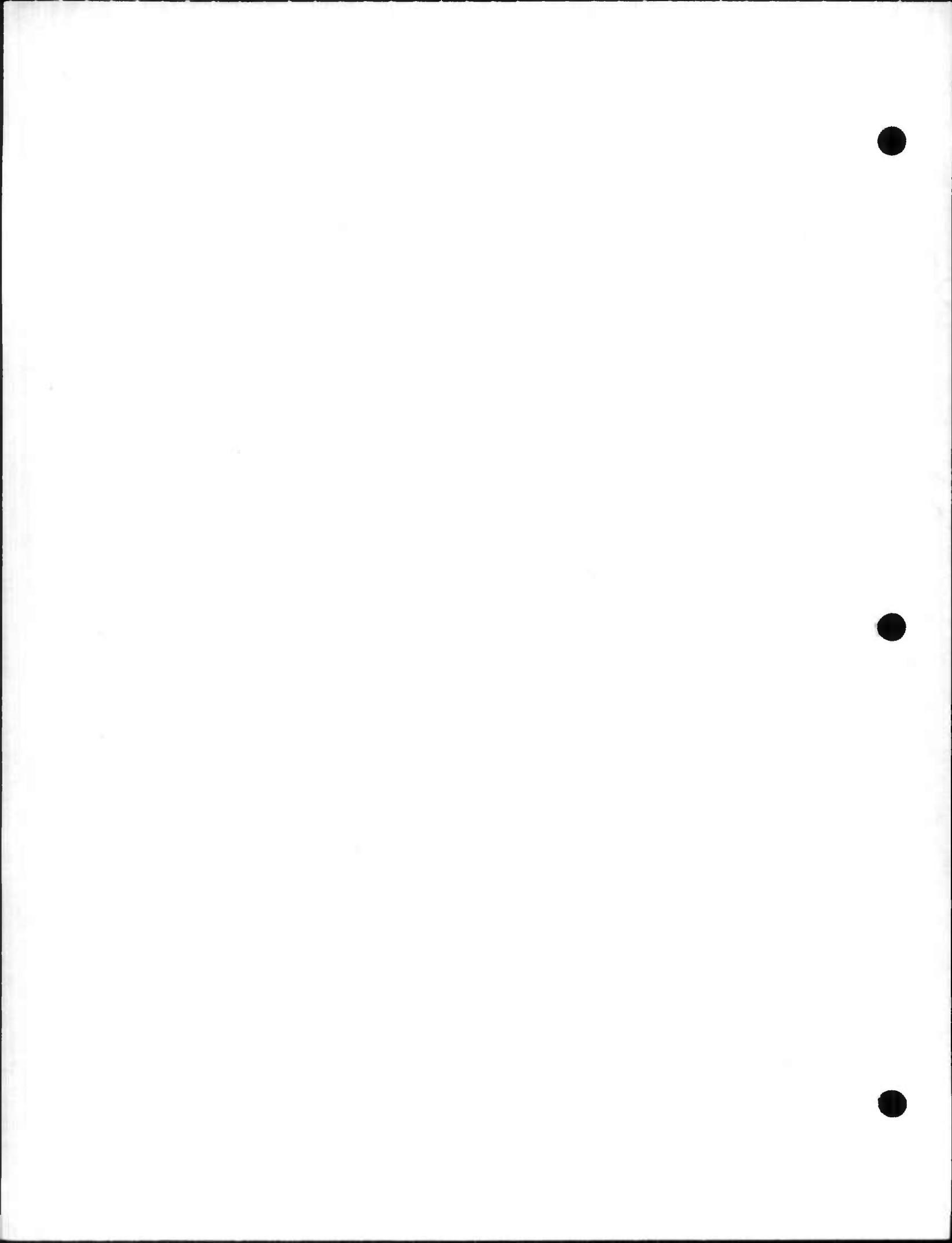
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - STATE REGISTRAR														
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
EDWARD JOSEPH LYDINGER												JUNE 4, 1995	23:41 PM	
4. SOCIAL SECURITY NUMBER			5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
216-38-2138			<input checked="" type="checkbox"/> M <input type="checkbox"/> F		54 YRS.		MONTHS		DAYS		HOURS MIN.			
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH										9c. COUNTY OF DEATH	
SACRED HEART HOSPITAL			CUMBERLAND										ALLEGANY	
RESIDENCE OF DECEDENT														
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
MD		Allegany		Cumberland										
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?				
847 Braddock Road		21502								USA				
11. MARITAL STATUS			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced														
15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY								
Elementary/Secondary (0-12) 12			College (1-4 or 8+) 4 Teacher			Backbone Mt. Camp								
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)								
Valentine J. Lydinger						Bertha M. (Day)								
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Valentine J. Lydinger			707 Maryland Avenue; Cumberland, MD 21502											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Mary's Cemetery			DATE 06/07			20c. LOCATION — City or Town, State Cumberland, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Scarpelli</i>			22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502											
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) →														
a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. HYPERTENSIVE CARDIOVASCULAR DISEASE 10 yrs DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. LICENSE NUMBER DO 923										29d. DATE SIGNED (Month, Day, Year) ► JUNE 5 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
R J 230 X 828 CUMBERLAND MD 21502														
31. DATE FILED (Month, Day, Year) JUN 06 1995			32. REGISTRAR'S SIGNATURE <i>Julia Dawson Marshall</i>											



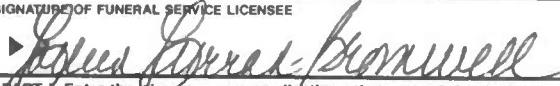
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

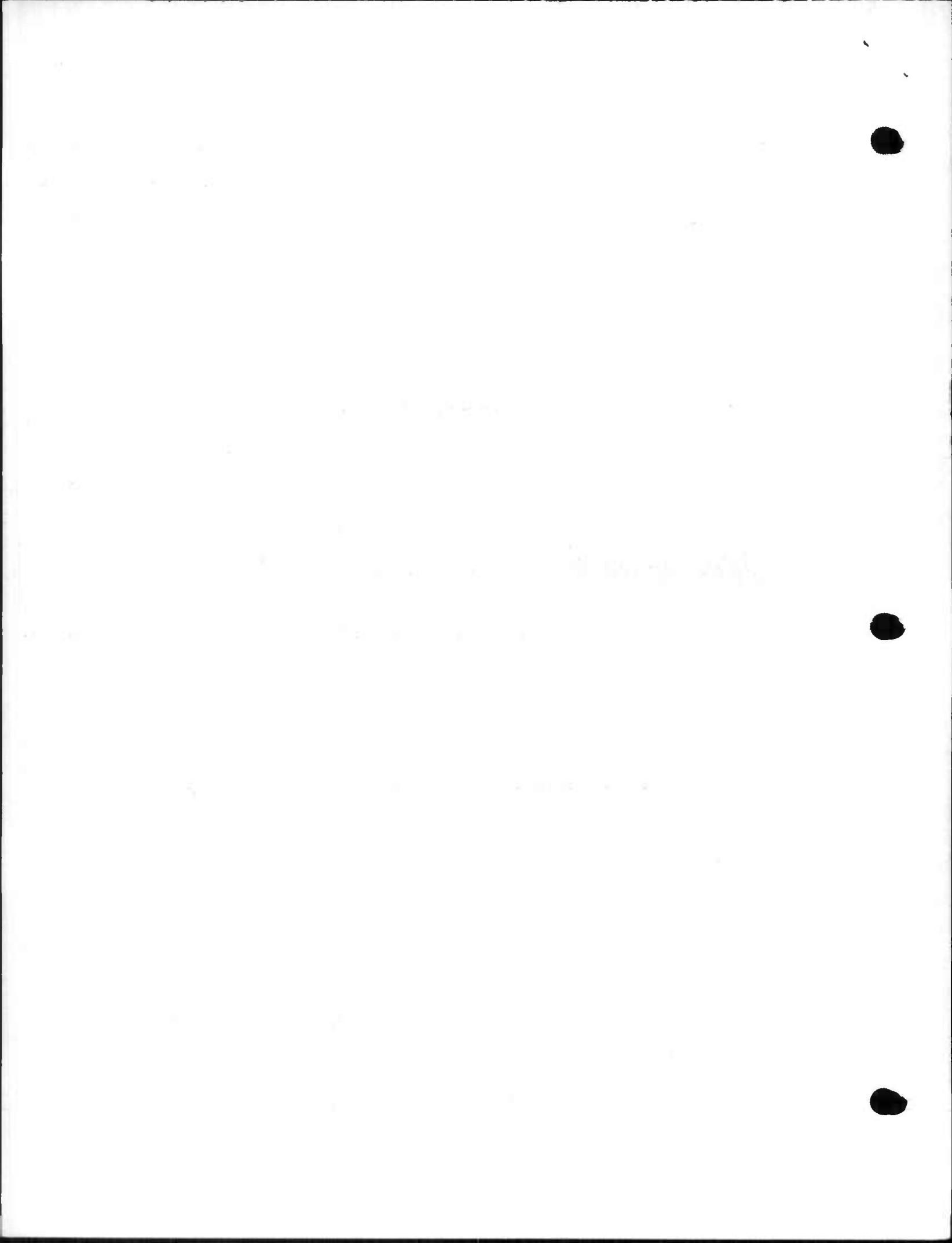
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Ulman L Lewis										2. DATE OF DEATH MONTH DAY YEAR June 09 1995	3. TIME OF DEATH 9:30 p.m.
4. SOCIAL SECURITY NUMBER 212-12-3888		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 28, 1915	8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) Dorchester General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cambridge			9c. COUNTY OF DEATH Dorchester				
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Dorchester	10c. CITY, TOWN OR LOCATION Fishing Creek						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 2508 Old House Point Road				10f. ZIP CODE 21634			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Factory Manager			16b. KIND OF BUSINESS/INDUSTRY Shellfish						
17. FATHER'S NAME (First, Middle, Last) Wilbur Lewis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Clara Travers							
19a. INFORMANT'S NAME (Type/Print) Novella Hattie Lewis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2508 Old House Point Rd., Fishing Creek, MD. 21634							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dorchester Mem. Park			DATE 6-13	20c. LOCATION — City or Town, State Cambridge, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Curran-Bromwell Funeral Home, P.A. 308 High St., Cambridge, MD. 21613							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death Sev. yrs.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe Chronic Obstructive Pulmonary Disease										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D15165			29d. DATE SIGNED (Month, Day, Year) ► 6/13/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mahmood Shariff 103 Aurora Street Cambridge, MD 21613											
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

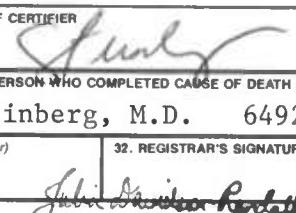
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

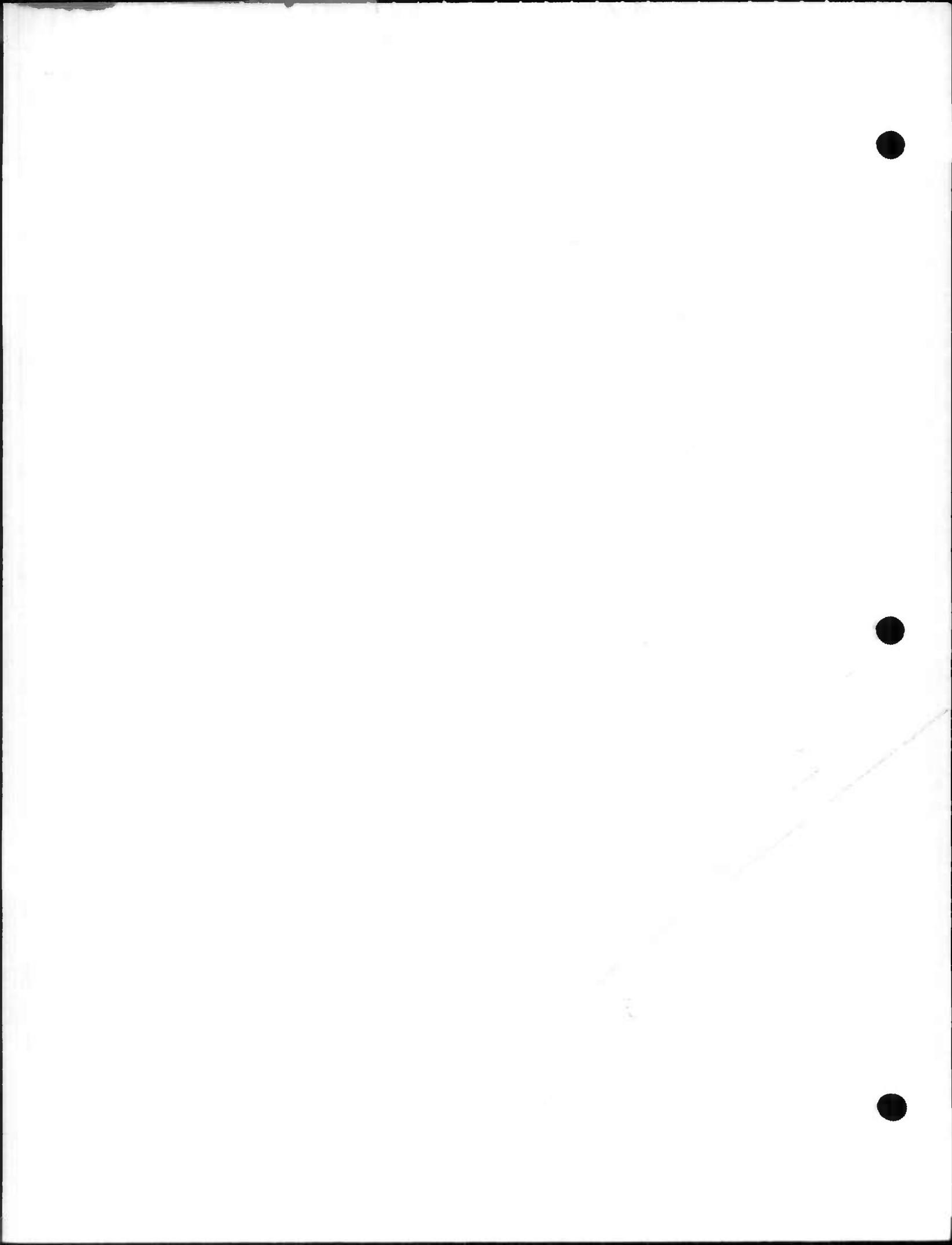
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH				
BASIL CLARENCE LILLY, JR.										May 31, 1995	6:20 A M				
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
215-20-3214		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		66 YRS.		MONTHS		DAYS		HOURS		MIN.			
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH			
5508 Berkley Manor Lane										Churchton		Anne Arundel			
RESIDENCE OF DECEDENT															
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
Maryland	Prince George's			Lanham											
10e. STREET AND NUMBER										10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
6413 Princess Garden Parkway										20706		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: American Indian			
1 Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY					
10		Installer								C & P Telephone Company					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Basil Clarence Lilly, Sr.										Eva Jane Anderson					
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Basil Clarence Lilly III										5508 Berkley Manor Lane, Churchton, Maryland 20733					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)					DATE	20c. LOCATION — City or Town, State				
					Fort Lincoln Cemetery 06/02/95						Brentwood, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										<p>a. <i>Bronchogenic carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Chronic Obstructive Pulmonary Disease</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Aneurysm Thoracic Aorta</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i></p>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aneurysm Thoracic Aorta</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  Louis E. Steinberg, M.D.										29c. LICENSE NUMBER D12015		29d. DATE SIGNED (Month, Day, Year) ► 6-1-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
Louis E. Steinberg, M.D. 6492 Landover Road, Landover, Maryland 20785-1451															
31. DATE FILED (Month, Day, Year) JUN 02 1995		32. REGISTRAR'S SIGNATURE 													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

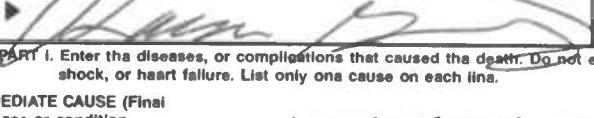
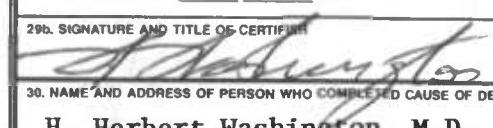
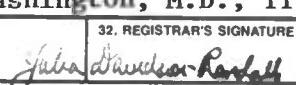
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

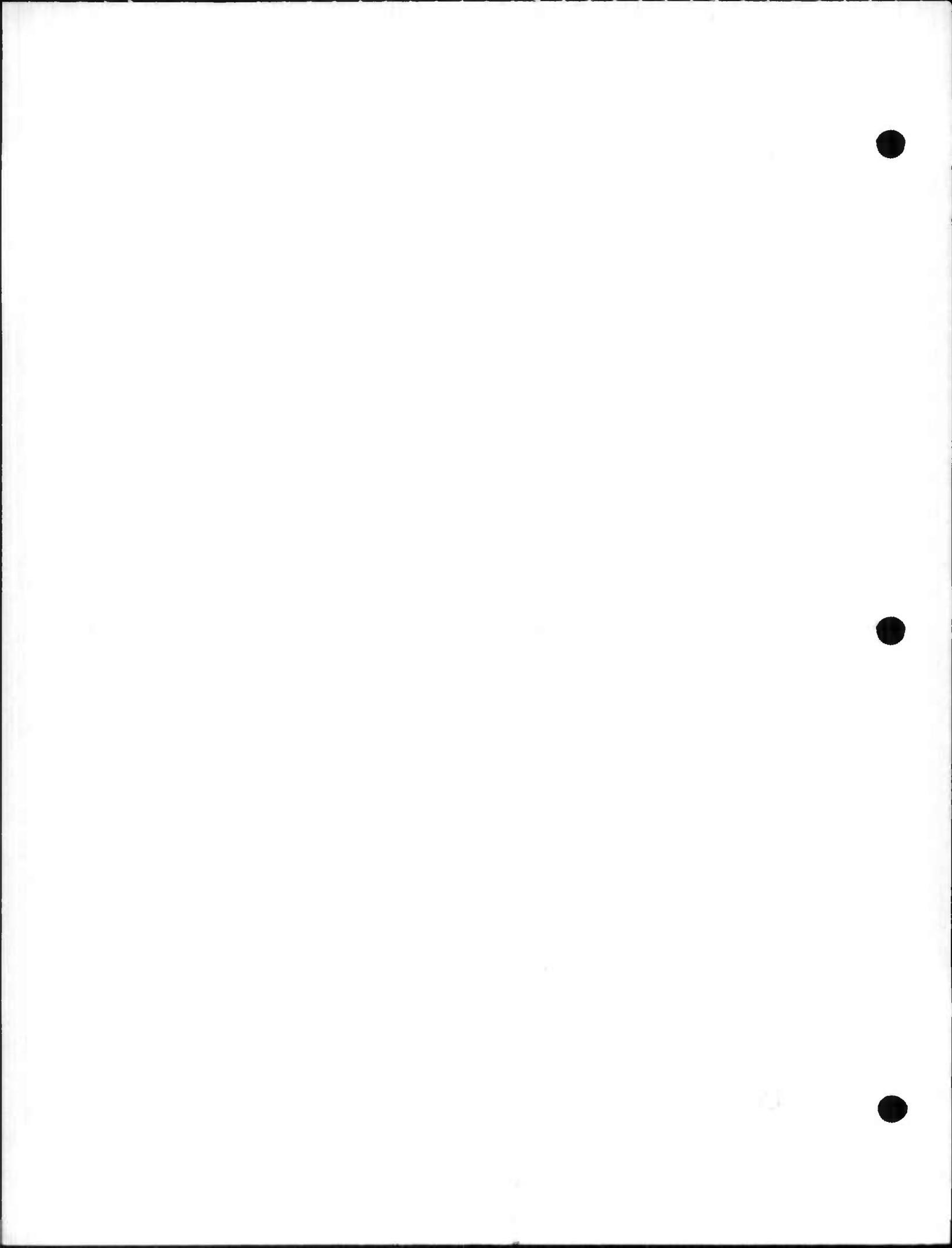
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

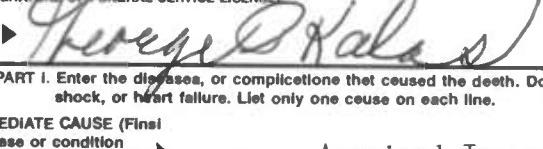
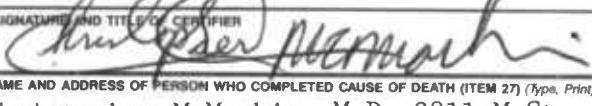
1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.
							2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
JUNE 3, 1995							8:00 A. M.		
1. DECEDENT'S NAME (First, Middle, Last) ARTHUR CURTIS LONGERBEAM							7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)	
4. SOCIAL SECURITY NUMBER 230-16-0409		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		Nov. 23, 1921	Virginia
9a. FACILITY NAME (If not institution, give street and number) Pinetree Nursing Home							9b. CITY, TOWN OR LOCATION OF DEATH Bryans Road		9c. COUNTY OF DEATH Charles County
RESIDENCE OF DECEDENT							10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10a. STATE Maryland	10b. COUNTY St. Mary's County	10c. CITY, TOWN OR LOCATION Mechanicsville					10g. CITIZEN OF WHAT COUNTRY? United States		
10e. STREET AND NUMBER 710 Thrasher Court							10f. ZIP CODE 20659	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter			16b. KIND OF BUSINESS/INDUSTRY Carpentry/Self-Employed				
17. FATHER'S NAME (First, Middle, Last) Arthur Clement Longerbeam							18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Marie Shetter		
19a. INFORMANT'S NAME (Type/Print) Helen Creighton							19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1790 Golden Beach Rd., Mechanicsville, MD 20659		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			DATE 6/6/95	20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 							22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate interval between onset and death Years		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Heart Disease									
DUE TO (OR AS A CONSEQUENCE OF):									
b. Hypertension DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29d. DATE SIGNED (Month, Day, Year) 6/5/95		
29b. SIGNATURE AND TITLE OF CERTIFIER 							29c. LICENSE NUMBER D32800	29d. DATE SIGNED (Month, Day, Year) 20744	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) H. Herbert Washington, M.D., 11701 Livingston Rd., Suite 306, Ft. Washington, MD									
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 							



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH			
Gary L. Loseke						June 5, 1995	7:00 A. M.			
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)	
507-58-0211		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	50 YRS.	MONTHS	DAYS	HOURS	MIN.	Dec. 8, 1944	Nebraska	
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH		
1600 Oakview Drive						Silver Spring		Montgomery		
RESIDENCE OF DECEDENT										
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION					10d. INSIDE CITY LIMITS?		
Maryland	Montgomery		Silver Spring					<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?		
1600 Oakview Drive						20903		U.S.A.		
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES					13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
15. DECEDENT'S EDUCATION (Specify only highest grade completed)	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY				
Elementary/Secondary (0-12)	College (14 or 5+)					Lawyer - Realtor				Legal - Real Estate
5+										
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Kenneth G. Loseke	Evelyn Ternus									
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Linda S. Loseke	1600 Oakview Dr., Silver Spring, Md. 20903									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)					DATE	20c. LOCATION — City or Town, State			
	Metropolitan Crematory					6/6/95	Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENCIATE 	22. NAME AND ADDRESS OF FACILITY									
	George P. Kalas Funeral Home									
	6160 Oxon Hill Rd. Oxon Hill, Md. 20745									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Acquired Immune Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF):					5 Years				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	{ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
Cytomegalovirus retinitis Mycobacterium Avium Complex										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide	28a. DATE OF INJURY (Month, Day, Year)					28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
	28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28d. DESCRIBE HOW INJURY OCCURRED				
29a. CERTIFIER (Check only one)	1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					281. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 	29c. LICENSE NUMBER 16615 (cx)					29d. DATE SIGNED (Month, Day, Year) ► June 5, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
Christopher McMackin, M.D. 2311 M St., N.W. #302, Wash., D.C. 20037										
31. DATE FILED (Month, Day, Year) JUN 06 1995	32. REGISTRAR'S SIGNATURE 									

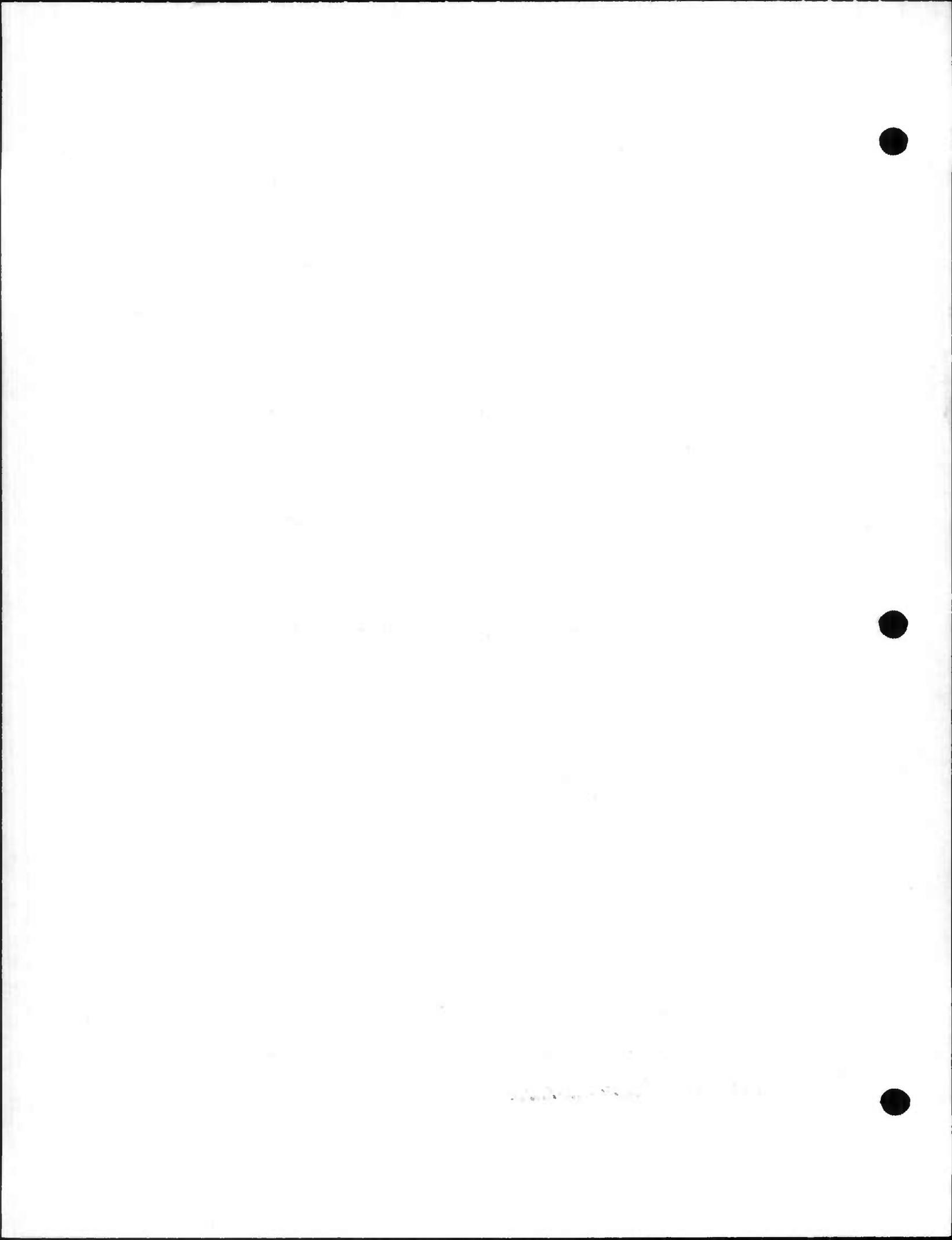
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

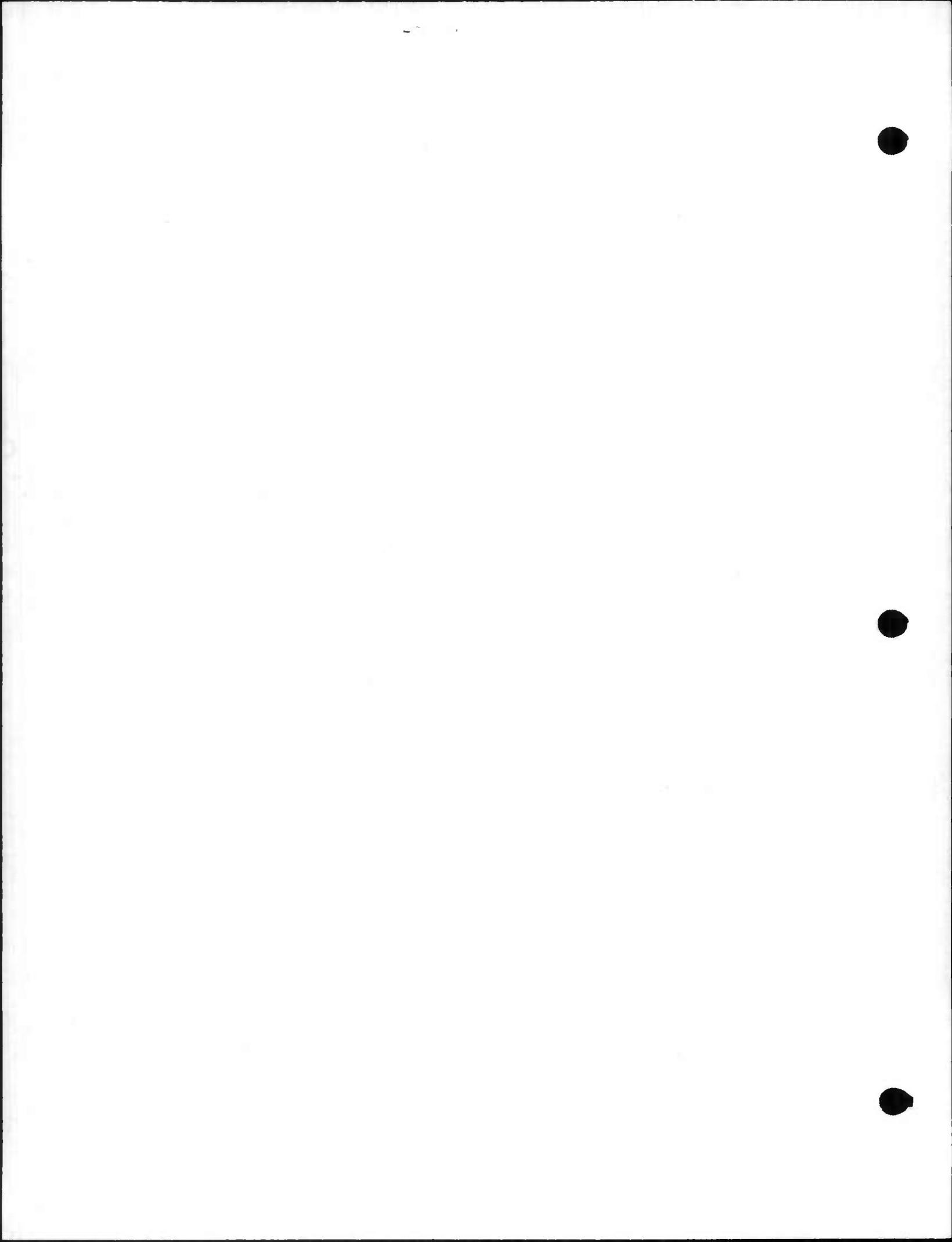
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or if item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

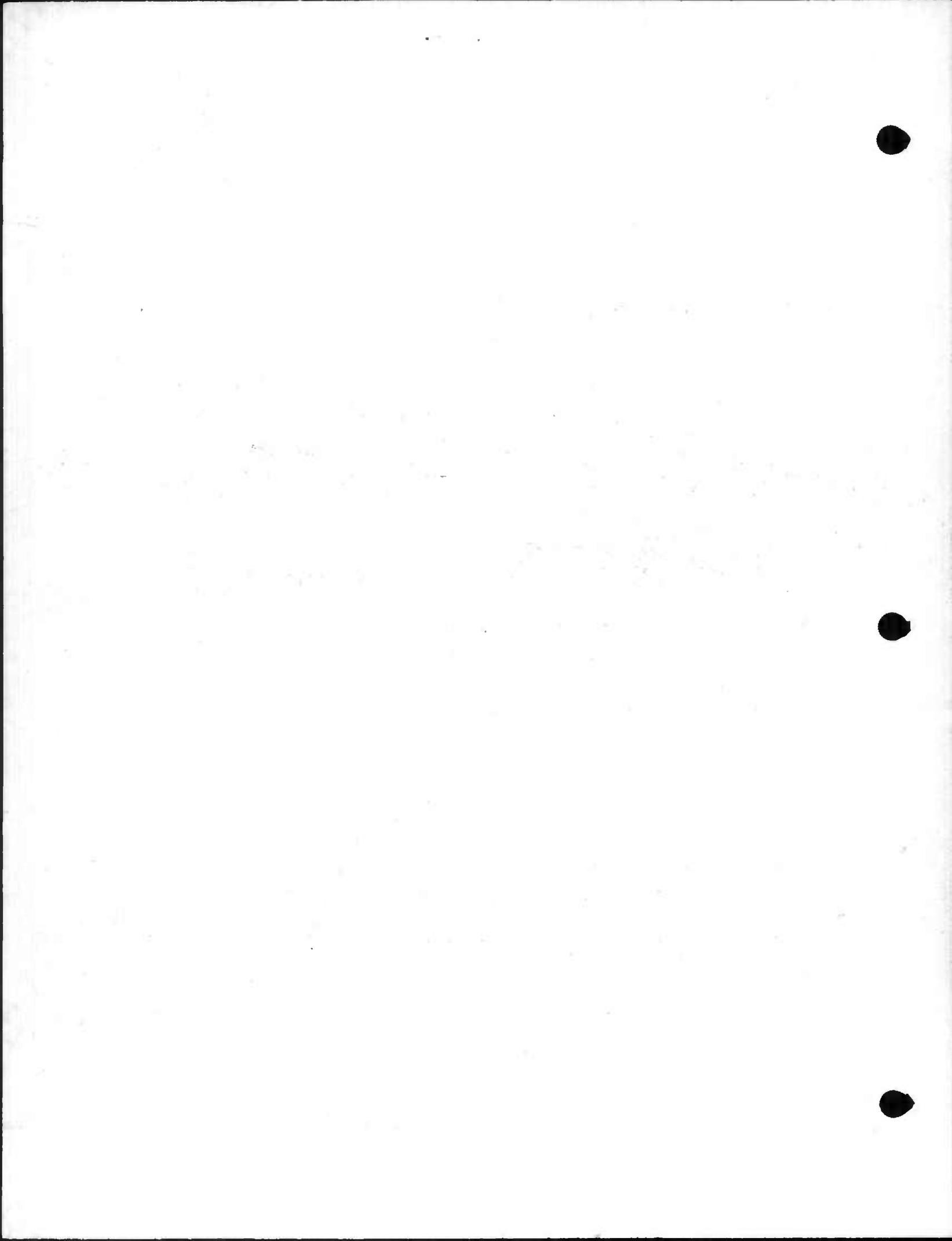
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										3. TIME OF DEATH 1:00 P M			
John George Lukinic												June 6, 1995			
4. SOCIAL SECURITY NUMBER 209-07-5660		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 22, 1917		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 5260 Hawthorne Road		9b. CITY, TOWN OR LOCATION OF DEATH La Plata										9c. COUNTY OF DEATH Charles			
RESIDENCE OF DECEASED															
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION La Plata								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5260 Hawthorne Rd.		10f. ZIP CODE 20646								10g. CITIZEN OF WHAT COUNTRY? U.S.A					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1940 - 1946		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:								14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Heavy Duty Mechanic		16b. KIND OF BUSINESS/INDUSTRY U.S. Government											
17. FATHER'S NAME (First, Middle, Last) John Lukinic		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lukinic													
19a. INFORMANT'S NAME (Type/Print) Anna Lukinic		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Trinity Memorial Gardens		20c. LOCATION — City or Town, State Waldorf, Maryland											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Williams Funeral Home, P.A. Rt. 225 & Glymont Rd., Indian Head, Md.													
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Approximate Interval Between Onset and Death													
a. <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):															
b. <i>Carcinoma of Liver</i> DUE TO (OR AS A CONSEQUENCE OF):															
c. <i>Carcinoma of Prostate</i> DUE TO (OR AS A CONSEQUENCE OF):															
d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>The last two to Bone</i>															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Henry L. Burke, M.D.</i>		29c. LICENSE NUMBER D-01009		29d. DATE SIGNED (Month, Day, Year) <i>6-6-95</i>											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Henry L. Burke, M.D.		115-A LaGrange Avenue, PO Box 591 La Plata, Maryland 20646													
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Julia Dawson-Pardell</i>													



FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) TONY LINASSI III												2. DATE OF DEATH MONTH JUNE DAY 6 YEAR 1995	3. TIME OF DEATH 7:00 P.M.
4. SOCIAL SECURITY NUMBER 217-60-2232			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 18 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar. 8, 1977	8. BIRTHPLACE (State or Foreign Country) Texas						
9a. FACILITY NAME (If not institution, give street and number) 310 COONEY NECK ROAD			9b. CITY, TOWN OR LOCATION OF DEATH MECHANICSVILLE			9c. COUNTY OF DEATH ST. MARY'S							
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY St. Mary's		10c. CITY, TOWN OR LOCATION Mechanicsville			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 450 Cooney Neck Road			10f. ZIP CODE 20659			10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Student		16b. KIND OF BUSINESS/INDUSTRY Education									
17. FATHER'S NAME (First, Middle, Last) Tony Linassi, Jr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Marie Cantor										
19a. INFORMANT'S NAME (Type/Print) Tony Linassi, Jr.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 450 Cooney Neck Road, Mechanicsville, MD 20659										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Benjamin Matthews M00658			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Veterans' Cem.			DATE 6-9	20c. LOCATION — City or Town, State Cheltenham, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Benjamin Matthews			22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home P. O. Box 156, Waldorf, MD 20604-0156										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → SHOTGUN WOUND OF HEAD													
DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) RESIDENCE			24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year) 6/6/1995		26b. TIME OF INJURY 5:41 P.M.	26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	26d. DESCRIBE HOW INJURY OCCURRED SUBJECT SHOT							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) RESIDENCE			27. LOCATION (Street and Number or Rural Route Number, City or Town, State) 310 COONEY NECK ROAD MECHANICSVILLE, MARYLAND								
29b. SIGNATURE AND TITLE OF CERTIFIER J. LARON LOCKE M.D.			29c. LICENSE NUMBER O.C.M.E.			29d. DATE SIGNED (Month, Day, Year) JUNE 9, 1995							
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE Jeanne L. Shuler-Randall											



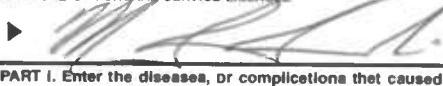
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

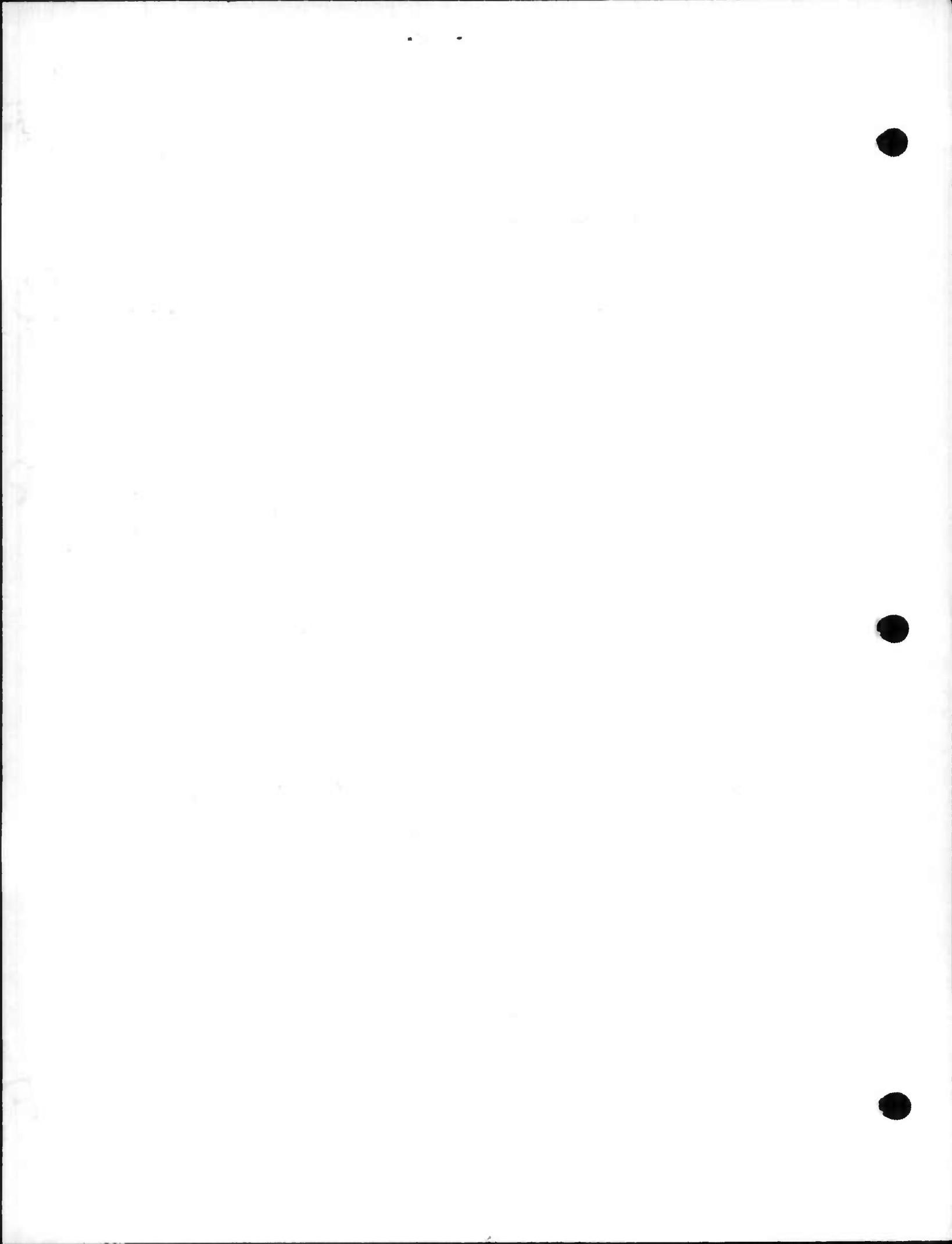
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR JUNE 11-1995									3. TIME OF DEATH 11:45 AM				
1. DECEASED'S NAME (First, Middle, Last) JEAN Elizabeth LOWE			4. SOCIAL SECURITY NUMBER 579-42-4001			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 14, 1934			8. BIRTHPLACE (State or Foreign Country) Washington, DC	
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN Maryland Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Clinton			9c. COUNTY OF DEATH Pelham-Bronx										
RESIDENCE OF DECEASED			10a. STATE Maryland			10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Harwood			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
10e. STREET AND NUMBER 4775-C Carmody Ct.									10f. ZIP CODE 20711							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMEED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Caucasian			14. RACE — American Indian, Black, White, etc. Specify: Caucasian							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A			16b. KIND OF BUSINESS/INDUSTRY Homemaker										
17. FATHER'S NAME (First, Middle, Last) Joseph Dove			18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred													
19a. INFORMANT'S NAME (Type/Print) Patty Connelley			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6865 Port Tobacco Road Indian Head Md. 20640													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery 1995			20c. LOCATION — City or Town, State Suitland, Maryland										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → RESPIRATORY FAILURE															48°	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST LUNG MASS															2 mos	
b. c. d.																
DUE TO (OR AS A CONSEQUENCE OF): CHRONIC OBSTRUCTIVE PULMONARY DISEASE																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide						28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. SIGNATURE AND TITLE OF CERTIFIER JOEL SEW CHAND MD			29c. LICENSE NUMBER D29646			29d. DATE SIGNED (Month, Day, Year) ► 6, 12, 95										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOEL SEW CHAND			3600 Leonardtown Rd #103 WALDORF, MD. 20601													
31. DATE FILED (Month, Day, Year) JUN 13 1995			32. REGISTRAR'S SIGNATURE Jean A. Mueller-Randall													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 6 hours after death. Page 6 may be retained by the hospital or attending physician.

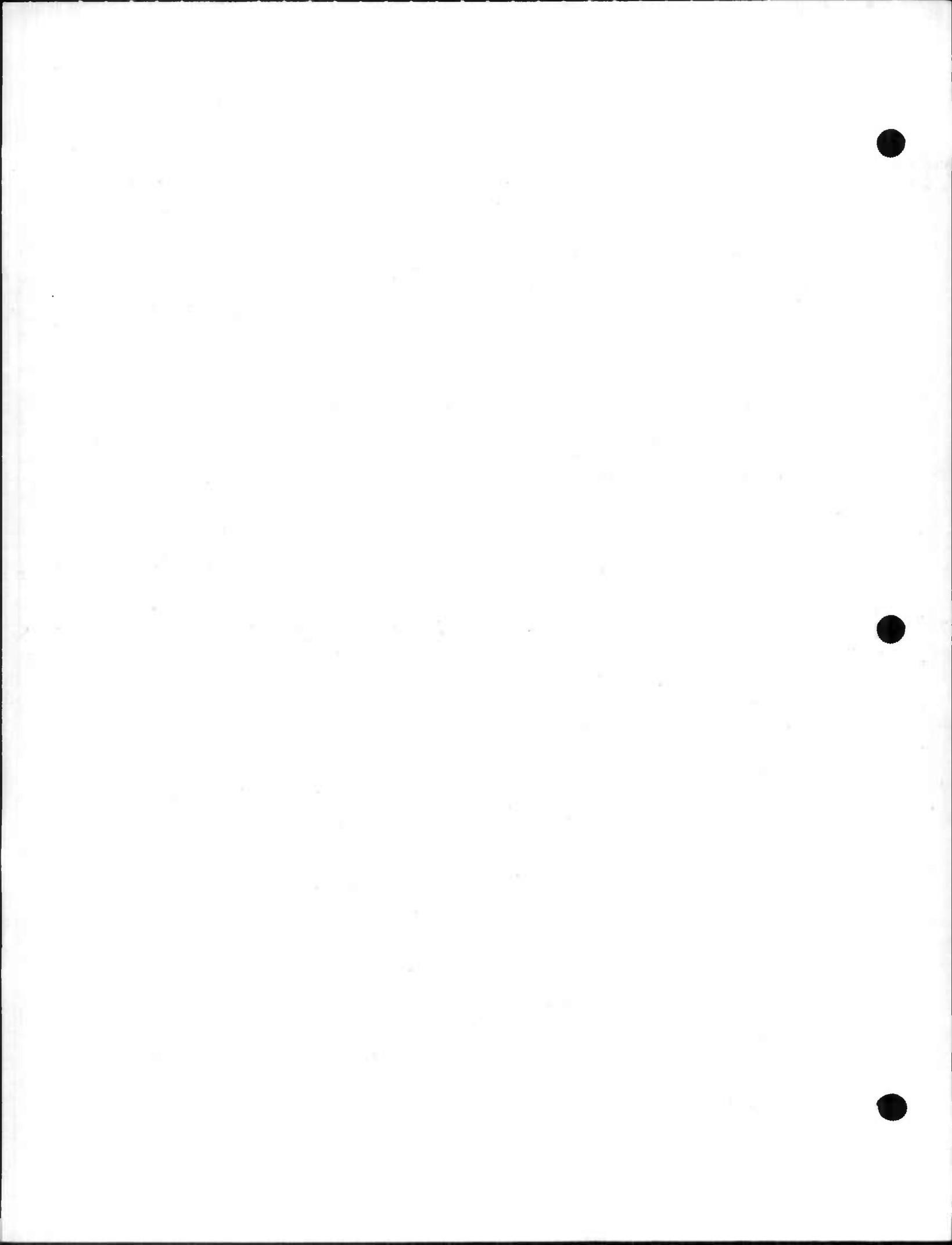
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.							
1 - STATE REGISTRAR												95 19098							
1. DECEDENT'S NAME (First, Middle, Last) Charles Eugene Lindsay, Sr.												2. DATE OF DEATH MONTH DAY YEAR June 12, 1995	3. TIME OF DEATH 0854 M						
4. SOCIAL SECURITY NUMBER 234 46 7059		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 13 1929		8. BIRTHPLACE (State or Foreign Country) West Virginia									
9a. FACILITY NAME (If not institution, give street and number) Calvert Memorial Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Prince Frederick		9c. COUNTY OF DEATH Calvert					
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10a. STATE Maryland		10b. COUNTY Calvert		10c. CITY, TOWN OR LOCATION Lusby								10g. CITIZEN OF WHAT COUNTRY? United States							
10e. STREET AND NUMBER 12635 Olivet Road		10f. ZIP CODE 20657								10h. RACE — American Indian, Black, White, etc. Specify: White									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1951-1953		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:															
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) fireman/ security Guard		16b. KIND OF BUSINESS/INDUSTRY Health care															
17. FATHER'S NAME (First, Middle, Last) Thomas Clark Lindsay		18. MOTHER'S NAME (First, Middle, Maiden Surname) Hazel Gertrude Phillips																	
19a. INFORMANT'S NAME (Type/Print) Florence E. Lindsay		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 562 Lusby, Maryland 20657																	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Hodges Chapel Church Cemetery		DATE June 17, 1995		20c. LOCATION — City or Town, State Dunn North Carolina													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► DRausch		22. NAME AND ADDRESS OF FACILITY Rausch Funeral Home 4405 Broomes Is. Rd. Port Republic MD																	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death one week							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Right Cerebral Infarction																			
DUE TO (OR AS A CONSEQUENCE OF): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):																			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ① Alvin Fibromia ② Right Internal carotid stenosis S/P												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 7 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) M		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED											
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Prince Frederick, MD 20678																	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER AT Munshi, M.D. Attending Physician		29c. LICENSE NUMBER 019427		29d. DATE SIGNED (Month, Day, Year) ► 6/12/95													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Anwar Munshi																			
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE Suzanne Randall																	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

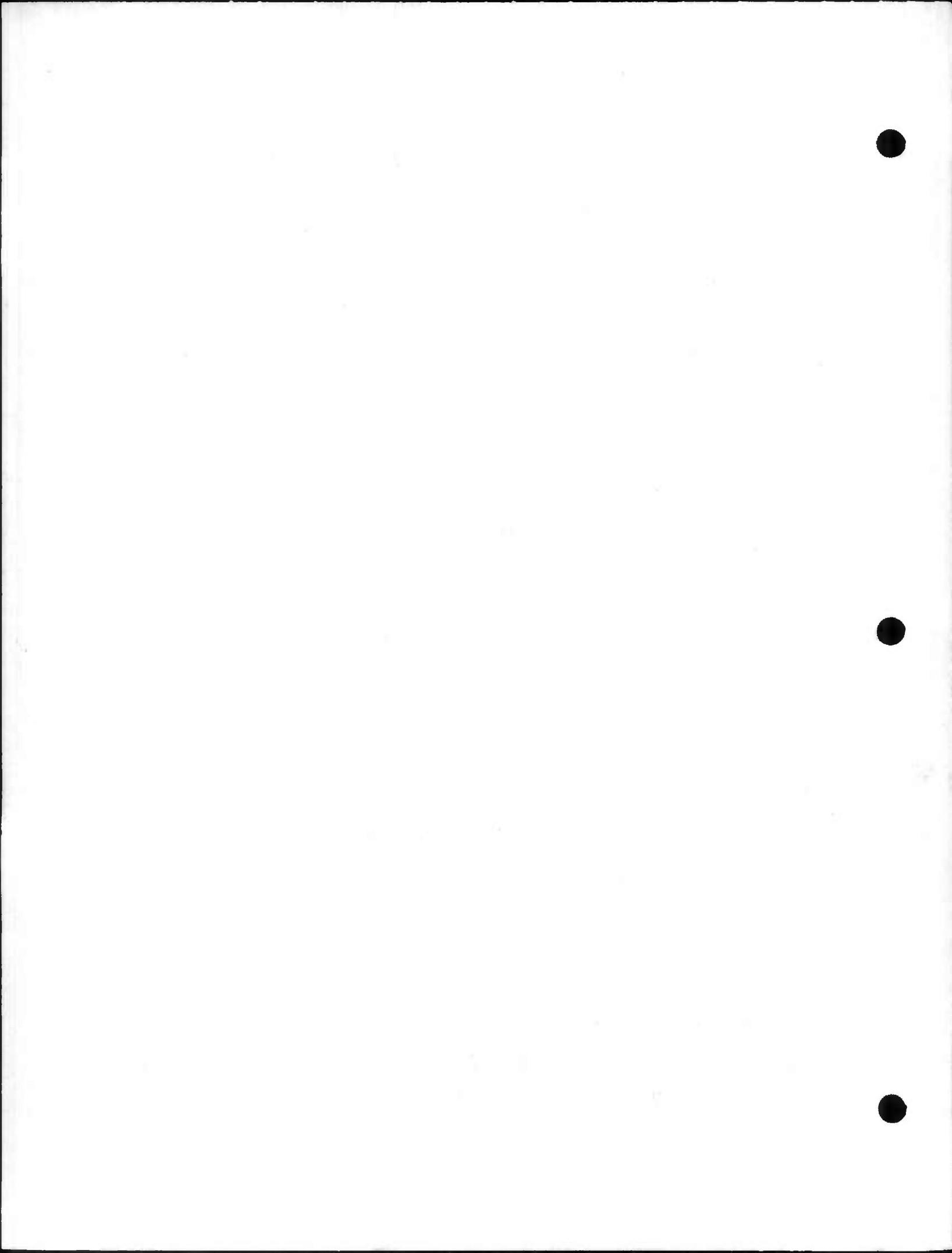
Amended #1+2, 6/16/95, LH., Fred. Co.

95 19099

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) CAROL LARGENT		Carol Hanna Langent				2. DATE OF DEATH MONTH June DAY 10 YEAR 95	3. TIME OF DEATH 155 P.M.
4. SOCIAL SECURITY NUMBER 217-38-8384		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 56 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) 11/19/38	8. BIRTHPLACE (State or Foreign Country) Baltimore MD
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Brunswick			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 11 Concord Drive				10f. ZIP CODE 21716			10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Homemaker		
17. FATHER'S NAME (First, Middle, Last) Lee Parker Childs				18. MOTHER'S NAME (First, Middle, Maiden Surname) Dorothy Hanna			
19a. INFORMANT'S NAME (Type/Print) Lewis Langent				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 Concord Drive, Brunswick, MD 21716			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Barbara A. Williams, Owner		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Camp Hill Cemetery DATE 6/14			20c. LOCATION — City or Town, State Paw Paw WV		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara A. Williams, Owner		22. NAME AND ADDRESS OF FACILITY John T. Williams Funeral Home 100 Petersville Rd., Brunswick MD					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. Subarachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p>							
Approximate Interval Between Onset and Death 1 day							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Kathleen W Stern MD		29c. LICENSE NUMBER D32073		29d. DATE SIGNED (Month, Day, Year) ► 6/10/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kathleen W Stern, MD, 610 Ninth Ave, Brunswick, Md. 21716							
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE John Stoeckle Parker					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

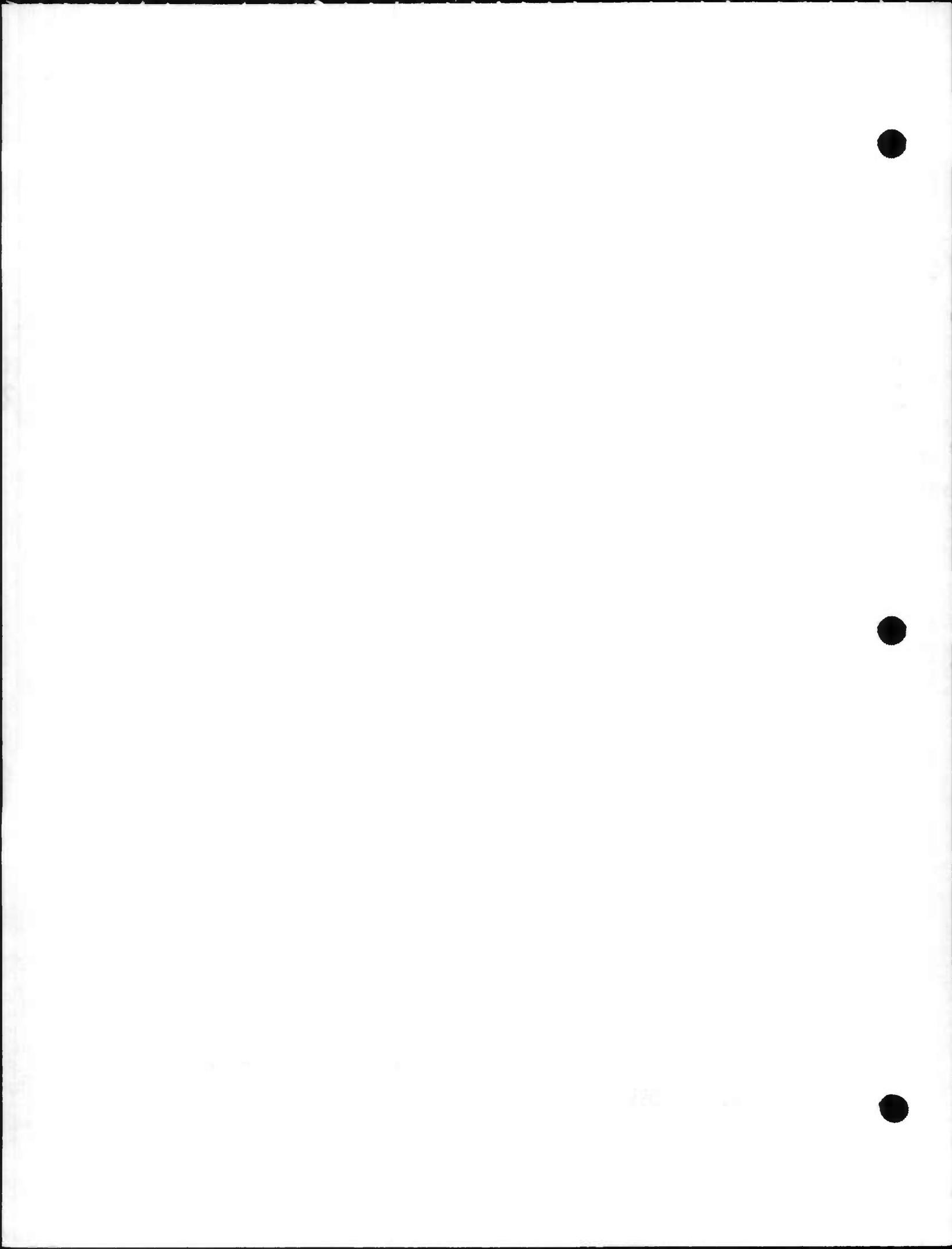
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		WILLIAM HOWARD LAYTON								2. DATE OF DEATH MONTH JUNE DAY 7, 1995 YEAR		3. TIME OF DEATH 11:15 P M	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 8, 1936		8. BIRTHPLACE (State or Foreign Country) Maryland	
215-38-9105		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		58 YRS.		MONTHS		DAYS		HOURS		MIN.	
9a. FACILITY NAME (If not institution, give street and number)		National Institute of Health								9b. CITY, TOWN OR LOCATION OF DEATH Bethesda		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEASED													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION Frederick								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland		Frederick		Frederick									
10e. STREET AND NUMBER		10f. ZIP CODE 21701								10g. CITIZEN OF WHAT COUNTRY? United States			
815 D Stratford Dr.													
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES / W.W. II								13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
1 Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Shipping Clerk								16b. KIND OF BUSINESS/INDUSTRY Manufacturing			
12													
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)											
Jessie Wilbur Layton		Mary Fransis Farraday											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 815-D, Stratford Dr./ Frederick, Md. 21701											
Shirley E. Layton													
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Crematory								DATE 6-9			
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										20c. LOCATION — City or Town, State Frederick, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raffit Hassan</i>		22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home 1621 Opossumtown Pike/Frederick, Md. 21702											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Bronchopneumonia DUE TO (OR AS A CONSEQUENCE OF):													
b. Non-Hodgkin's lymphoma DUE TO (OR AS A CONSEQUENCE OF):													
c. (LAST) DUE TO (OR AS A CONSEQUENCE OF):													
d. (LAST) DUE TO (OR AS A CONSEQUENCE OF):													
Approximate Interval Between Onset and Death → 3 days → > 1 yr.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Raffit Hassan MD</i>		29c. LICENSE NUMBER 28996 IA								29d. DATE SIGNED (Month, Day, Year) ► 6/8/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAFFIT HASSAN National Institute of Health, Bethesda, MD													
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE <i>Julia Dawson-Randall</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2b is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

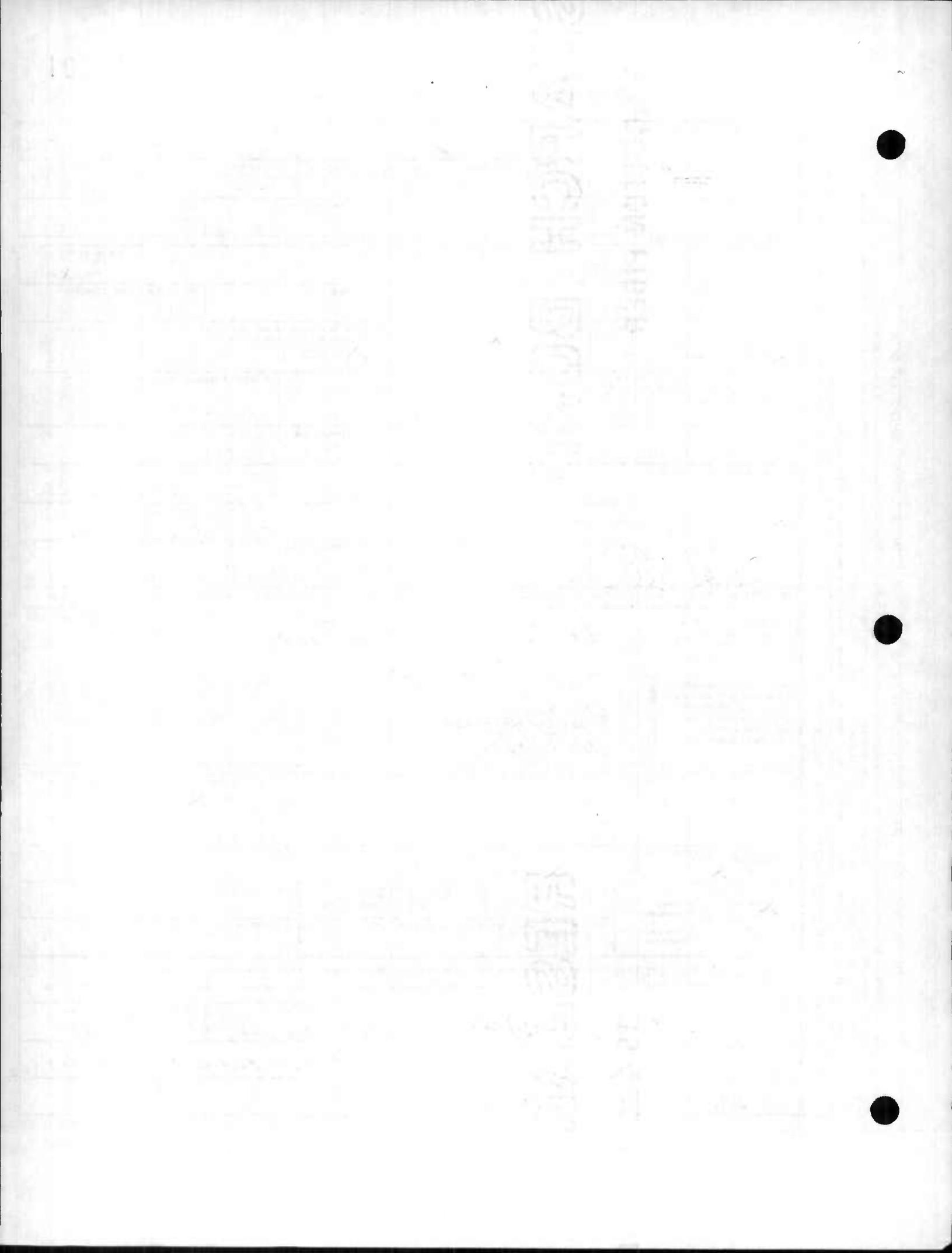
AMENDED #4, 6/19/95, B.P., WORCESTER CO.

95 19101

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		RUTH E. LEONARD				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH M								
4. SOCIAL SECURITY NUMBER 187-12-0067		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-3-22	8. BIRTHPLACE (State or Foreign Country) PA.								
8a. FACILITY NAME (If not institution, give street and number) ATLANTIC GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BERLIN				9c. COUNTY OF DEATH WORCESTER									
RESIDENCE OF DECEDENT															
10a. STATE MD	10b. COUNTY WORCESTER	10c. CITY, TOWN OR LOCATION OCEAN CITY				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 12346 OLD BRIDGE Rd.		10f. ZIP CODE 21842				10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> ND IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY HOMEMAKER											
17. FATHER'S NAME (First, Middle, Last) EDGAR STRAUSSER		18. MOTHER'S NAME (First, Middle, Maiden Surname) EDNA STRAUSSER													
19a. INFORMANT'S NAME (Type/Print) CINDY LEONARD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12346 OLD BRIDGE Rd. OCEAN CITY, MD., 21842													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) OAK LAWN CEMETERY			DATE 6-9	20c. LOCATION — City or Town, State BALTO. Co., MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY ULLRICH FUNERAL HOME BERLIN, MD.													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Acute Heart attack</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Obesity</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i>Arthritis</i></p>															
Approximate Interval Between Onset and Death															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <table border="0"> <tr> <td><input checked="" type="checkbox"/> Natural</td> <td><input type="checkbox"/> Pending investigation</td> </tr> <tr> <td><input type="checkbox"/> Accident</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Suicide</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Homicide</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide		<input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> ND	28d. DESCRIBE HOW INJURY OCCURRED		
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation														
<input type="checkbox"/> Accident															
<input type="checkbox"/> Suicide															
<input type="checkbox"/> Homicide															
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 202329				29d. DATE SIGNED (Month, Day, Year) 6/6/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANDRES C. GOMEZ, M.D. 105 64th St. Ocean City, Md. 21842		32. REGISTRAR'S SIGNATURE 													
31. DATE FILED (Month, Day, Year) JUN 07 1995						DHMH-16 Rev 1/89									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

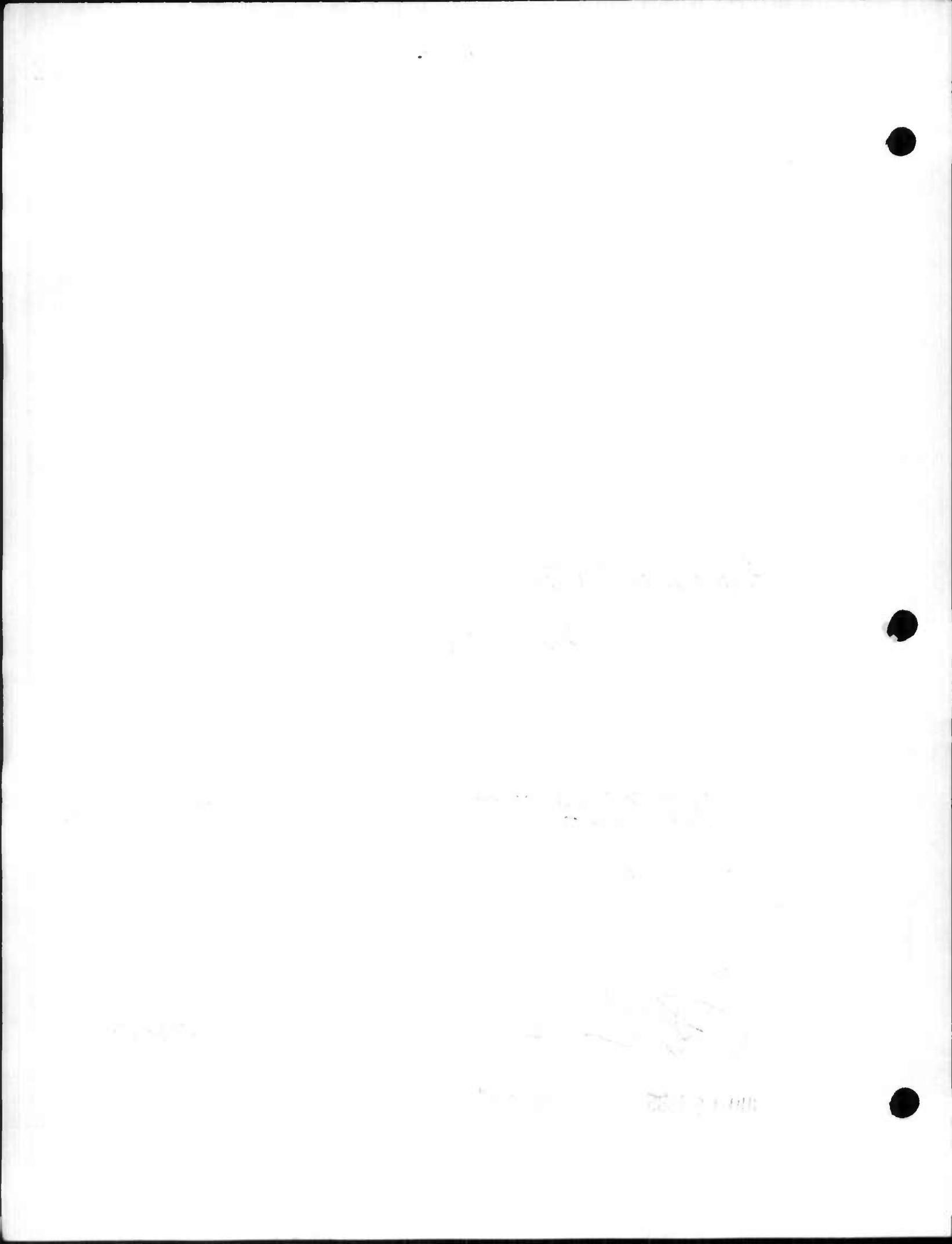
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR														
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH			
Henry Clay LEWIS, Sr.										June 17, 1995	1:45a M			
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)			
220-10-2801		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	87 YRS.	MONTHS	DAYS	HOURS	MIN.			Jan. 22, 1908	West Virginia			
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH			
Garrett County Memorial Hospital										Oakland	Garrett			
RESIDENCE OF DECEDENT														
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
Maryland		Garrett		Oakland										
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?			
2449 Oakland-Sang Run Road										21550	USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced														
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY								
Elementary/Secondary (0-12) 7th		College (1-4 or 5+)				Mechanic						Auto/ County Roads Dept.		
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)				
Emory Elwood Lewis										Mary Matilda Hardesty				
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)				
Hester Lewis										2449 Oakland-Sang Run Road Oakland, MD 21550				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State						
		Lewis Cemetery				6/21		Oakland, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Franklin L. Custer</i>										22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St. Oakland, MD 21550				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition → resulting in death) → <i>Pneumonia</i>														
b. DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Parkinson's Disease old CVA</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accidental 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED								
		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO												
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Robert A. Goralski</i>		29c. LICENSE NUMBER D23979				29d. DATE SIGNED (Month, Day, Year) <i>6/1/95</i>								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
Dr. Robert A. Goralski, MD 311 N. Fourth Street Oakland, MD 21550														
31. DATE FILED (Month, Day, Year) <i>JUN 19 1995</i>														
32. REGISTRAR'S SIGNATURE <i>Julie Steiner-Randall</i>														



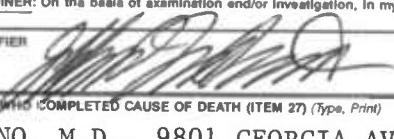
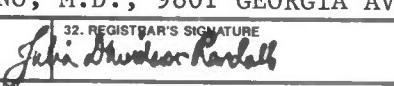
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

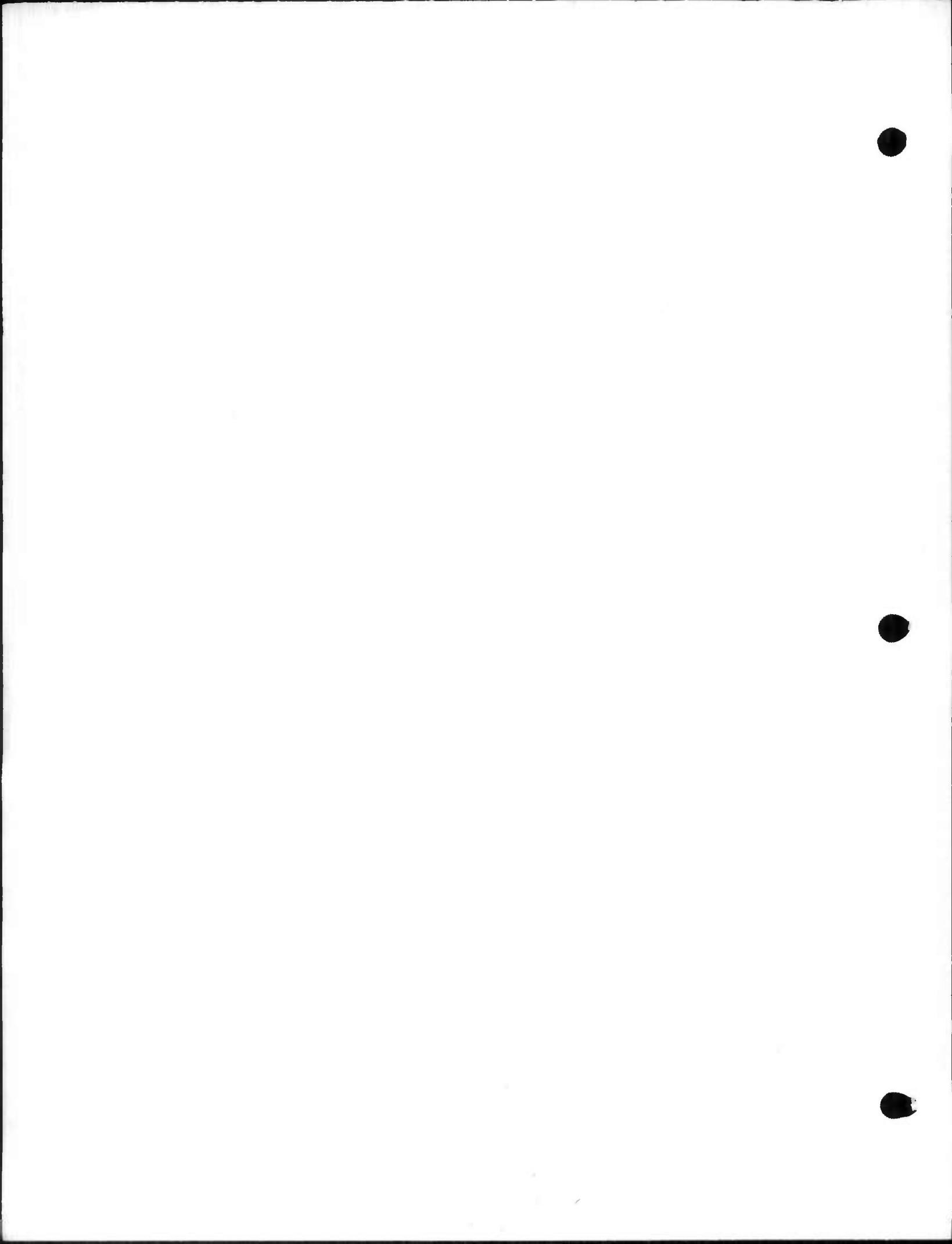
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) THEODORE MEHALOFF										2. DATE OF DEATH MONTH DAY YEAR JUNE 7, 1995	3. TIME OF DEATH 12:00 P M		
4. SOCIAL SECURITY NUMBER 144-10-3174		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JULY 10, 1905			8. BIRTHPLACE (State or Foreign Country) RUSSIA		
9a. FACILITY NAME (If not institution, give street and number) SPRINGBROOK ADVENTIST NURSING HOME										9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING	9c. COUNTY OF DEATH MONTGOMERY		
RESIDENCE OF DECEDENT													
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION SILVER SPRING								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 12325 NEW HAMPSHIRE AVENUE					10f. ZIP CODE 20904				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2			16b. KIND OF BUSINESS/INDUSTRY PHARMACEUTICALS / OWN STORE							
17. FATHER'S NAME (First, Middle, Last) EZAK MEHALOFF					18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNIE SEGAL								
19a. INFORMANT'S NAME (Type/Print) JUDITH JACOBS (DAUGHTER)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2427 CHURCHILL ROAD, SILVER SPRING, MD 20902								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. LEBANON				20c. LOCATION — City or Town, State 6/11 ADELPHI, MARYLAND					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate interval Between Onset and Death			
a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):										1 year			
b. <i>Necrotic Osteomyelitis</i> DUE TO (OR AS A CONSEQUENCE OF):										5 years			
c. <i>Diabetes mellitus</i> DUE TO (OR AS A CONSEQUENCE OF):										1 yr			
d. <i>Ischemic Skin Necrosis</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 37975				29d. DATE SIGNED (Month, Day, Year) JUNE 8, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY INDRISANO, M.D., 9801 GEORGIA AVENUE, SILVER SPRING, MD SUITE #340													
31. DATE FILED (Month, Day, Year) JUN 09 1995													
32. REGISTRAR'S SIGNATURE 													

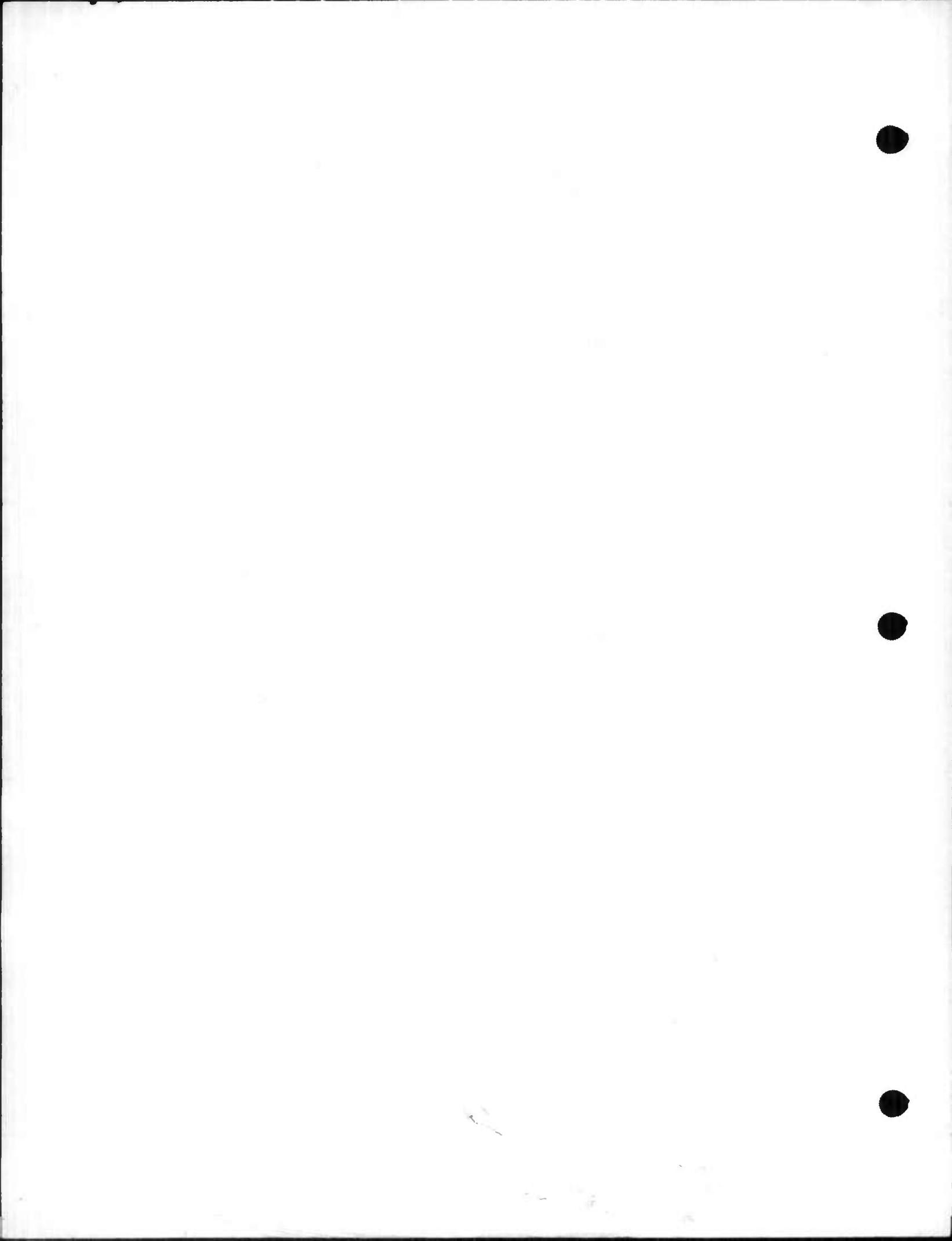


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Edwin Francis McCann												2. DATE OF DEATH MONTH DAY YEAR June 5, 1995	3. TIME OF DEATH 6:55 A.M.
4. SOCIAL SECURITY NUMBER 522-26-3532		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 16, 1924		8. BIRTHPLACE (State or Foreign Country) Colorado			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring				9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO						
10e. STREET AND NUMBER 1707 Sherwood Road				10f. ZIP CODE 20902				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 1 Administrative Officer			16b. KIND OF BUSINESS/INDUSTRY Federal Government								
17. FATHER'S NAME (First, Middle, Last) Gerald E. McCann				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Pearson									
19a. INFORMANT'S NAME (Type/Print) Juanita A. McCann				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 Sherwood Road Silver Spring, Maryland 20902									
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parklawn Memorial Park			DATE 6/8/95		20c. LOCATION — City or Town, State Rockville, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Mark J. Miller				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → respiratory arrest <small>DUE TO (OR AS A CONSEQUENCE OF):</small> Severe sepsis <small>DUE TO (OR AS A CONSEQUENCE OF):</small> Cancer of the throat <small>DUE TO (OR AS A CONSEQUENCE OF):</small> d.													
Approximate Interval Between Onset and Death respiratory arrest immed Severe sepsis 2 days Cancer of the throat 7 mos													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Trachostomy													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)											
27. MANNER OF DEATH 1 X Natural 5 □ Pending investigation 2 □ Accident 6 □ Homicide 3 □ Suicide 7 □ Could not be determined 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29c. SIGNATURE AND TITLE OF CERTIFIER Richard P. Delaney, M.D.		29d. LICENSE NUMBER DO2338		29e. DATE SIGNED (Month, Day, Year) ► 6/5/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard P. Delaney, M.D. 9801 Georgia Avenue #109 Silver Spring, Maryland 20902													
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE Jahi Shuler-Rodell											



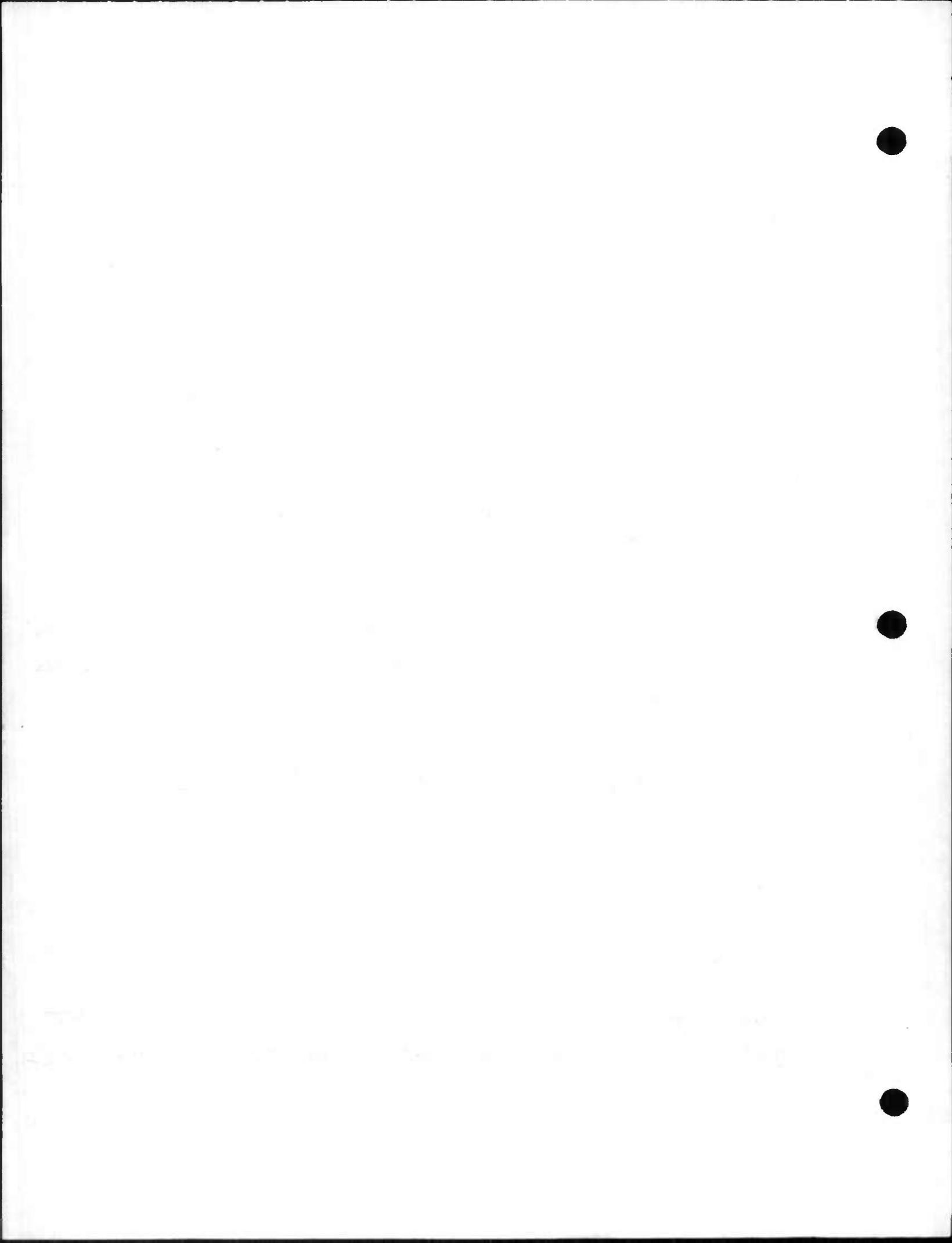
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.									
1. STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										3. TIME OF DEATH P.M.									
JUNE 3, 1995												13:58									
1. DECEASED'S NAME (First, Middle, Last) JAMES M. MULLEN SR.												4. SOCIAL SECURITY NUMBER 579-05-3218	5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MAY 1, 1913	8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.			
9a. FACILITY NAME (If not institution, give street and number) MONTGOMERY GENERAL HOSPITAL												9b. CITY, TOWN OR LOCATION OF DEATH OLNEY			9c. COUNTY OF DEATH MONTGOMERY						
RESIDENCE OF DECEASED												10a. STATE MARYLAND			10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION DAMASCUS			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9901 BELLISON ROAD												10f. ZIP CODE 20872			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: 			14. RACE — American Indian, Black, White, etc. Specify: WHITE													
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY STAGE HAND			16c. LOCATION — City or Town, State ENTERTAINMENT													
17. FATHER'S NAME (First, Middle, Last) JAMES M. MULLEN		18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL KING			19a. INFORMANT'S NAME (Type/Print) CATHY A. CHILDS			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9901 BELLISON ROAD DAMASCUS, MARYLAND 20872													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery, or other place) PARKLAWN CEMETERY			20c. DATE 6/6/95			20c. LOCATION — City or Town, State ROCKVILLE, MARYLAND													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barker		22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 20882 P. O. BOX 5038 LAYTONSVILLE, MARYLAND																			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cerebrovascular accident												hours									
b. Hypertension												years									
c. 																					
d. 																					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin dependent diabetes mellitus												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Reelidence 6 <input type="checkbox"/> Other (Specify)										24c. LOCATION (Street and Number or Rural Route Number, City or Town, State) 									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED												
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 													
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER DO5809			29d. DATE SIGNED (Month, Day, Year) ► 6-4-95																
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOHN G. LODMELL MD. 2901 Olney Rd. Olney, Md 20832		32. REGISTRAR'S SIGNATURE Juli Anderson Robell																			
31. DATE FILED (Month, Day, Year) JUN 05 1995																					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

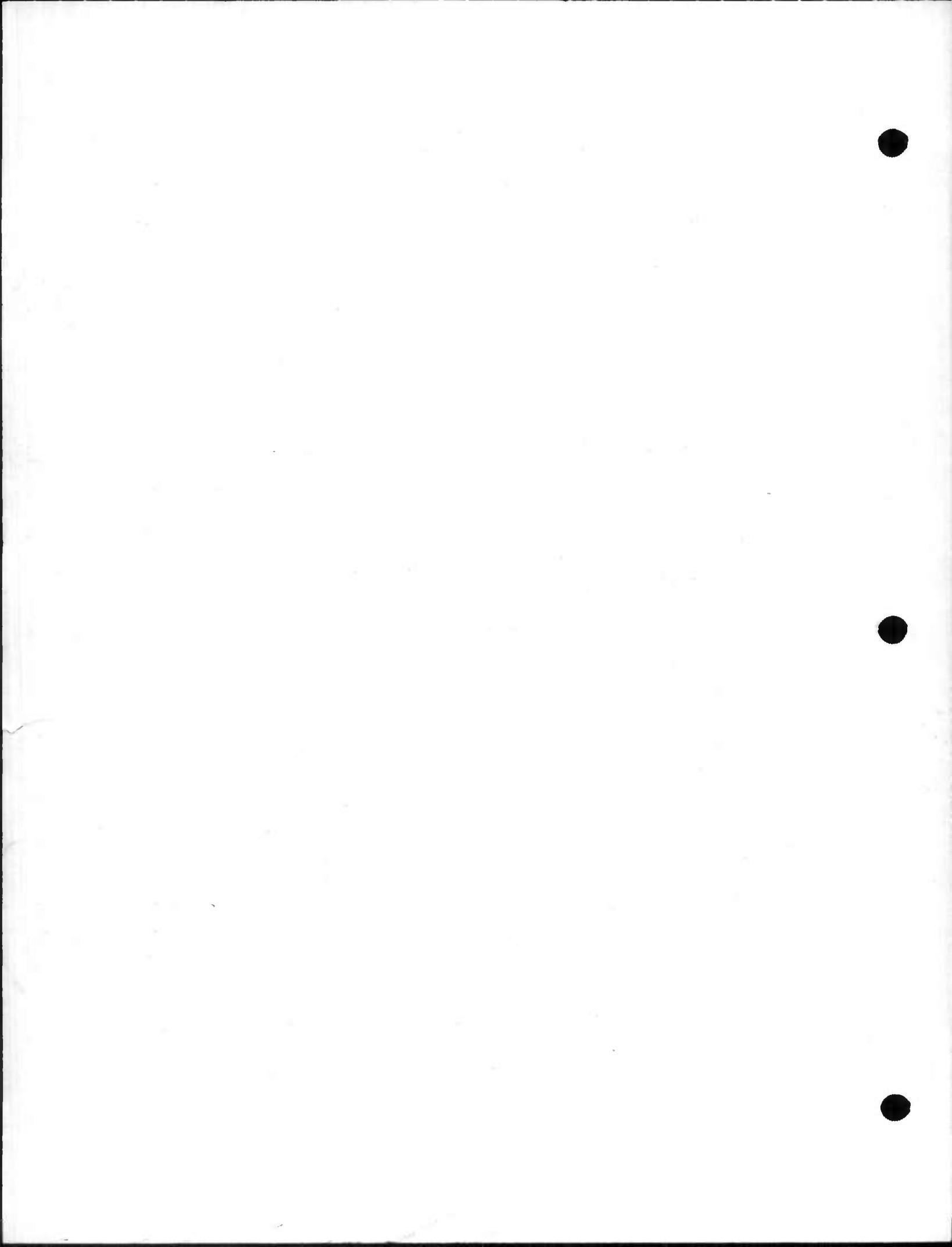
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		NOLEN EDWARD MILLER								2. DATE OF DEATH MONTH JUNE DAY 2 YEAR 95	3. TIME OF DEATH 07:30 A.M.
4. SOCIAL SECURITY NUMBER 577-03-7478		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS		7. DATE OF BIRTH (Month, Day, Year) April 12, 1909		8. BIRTHPLACE (State or Foreign Country) Virginia	
8a. FACILITY NAME (If not institution, give street and number) Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda								9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEASED											
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Damascus								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10009 Damascus Hill Court				10f. ZIP CODE 20872				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify:			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Salesman			16b. KIND OF BUSINESS/INDUSTRY Automobile						
17. FATHER'S NAME (First, Middle, Last) John A. Miller					18. MOTHER'S NAME (First, Middle, Maiden Surname) Gladys Eva Reamy						
19a. INFORMANT'S NAME (Type/Print) Dawn M. Hurley					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10009 Damascus Hill Court Damascus, Maryland 20872						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Miller Family Cemetery			DATE 6/5/95	20c. LOCATION — City or Town, State Catlett, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Andrew J. Cole				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. S11.Spr., MD 20901							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE TRAUMA DUE TO (OR AS A CONSEQUENCE OF):											
Approximate Interval Between Onset and Death 62 DAYS											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY APRIL 1, 95		28b. TIME OF INJURY 0730 M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED HE PARKED CARY TREE ROAD					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									
29b. SIGNATURE AND TITLE OF CERTIFIER FRANCIS C. MAYNE		29c. LICENSE NUMBER DO7099				29d. DATE SIGNED (Month, Day, Year) ► JUNE 2 95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAYNE 10215 FERNWOOD RD BETHESDA MD 20817											
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE Julie Davidson Randall									



DIVISION OF VITAL RECORDS, P.O. BOX 687600

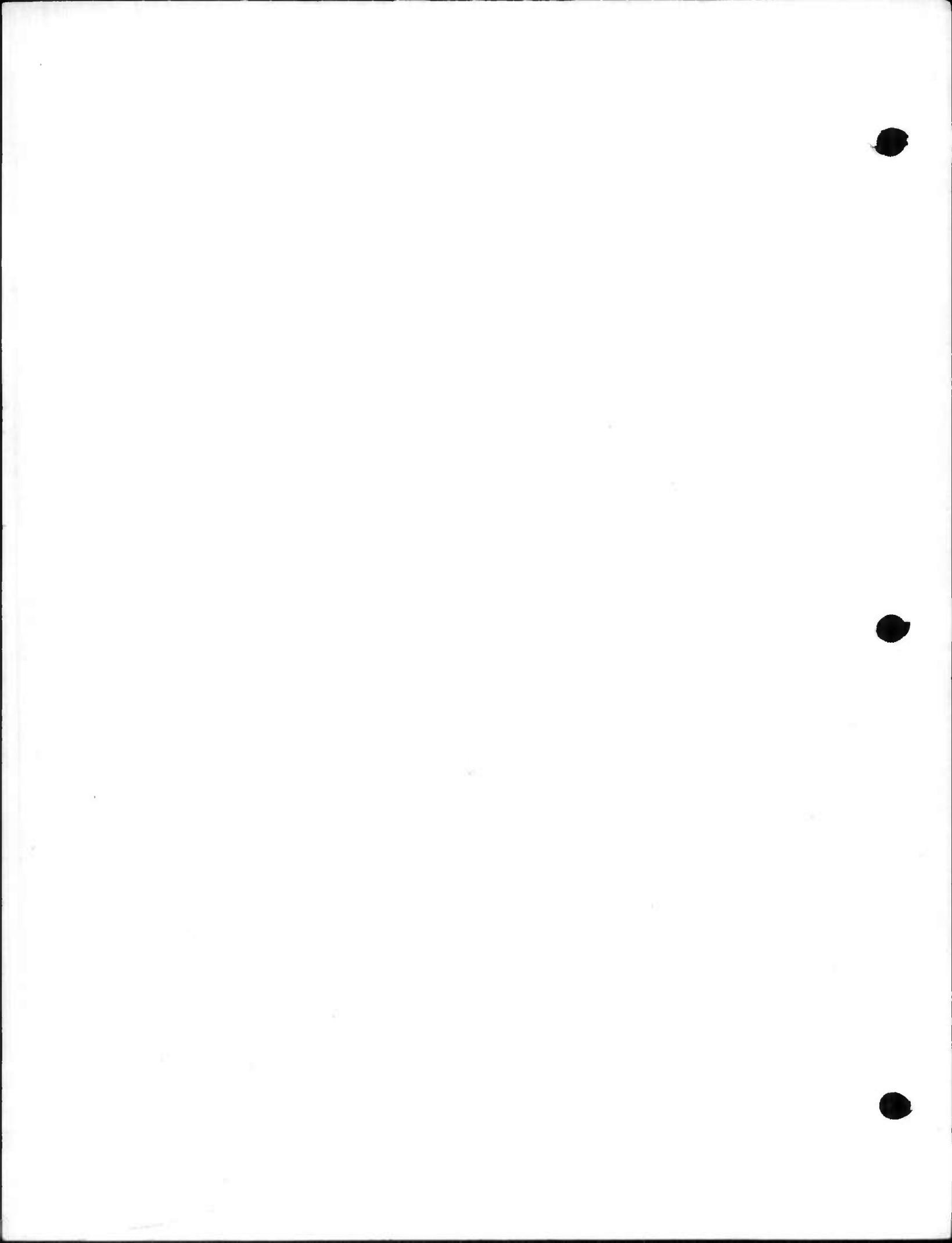
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

Amended #6 6/6/95 MRT Montgomery County.		95 19107	
FOR 1 - STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH	
		REG. NO.	
<p>1. DECEDENT'S NAME (First, Middle, Last) KENNETH G. McIntyre, Sr.</p> <p>4. SOCIAL SECURITY NUMBER 214-76-6737</p> <p>5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</p> <p>6. AGE (In yrs. last birthday) 77 78 YRS.</p> <p>7. DATE OF DEATH MONTH 6 DAY 1 YEAR 95</p> <p>8. BIRTHPLACE (State or Foreign Country) Jamaica</p> <p>9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital</p> <p>9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring</p> <p>9c. COUNTY OF DEATH Montgomery</p> <p>RESIDENCE OF DECEDENT</p> <p>10a. STATE West Indies</p> <p>10b. COUNTY Maypen</p> <p>10c. CITY, TOWN OR LOCATION Denbigh, Jamaica</p> <p>10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>10e. STREET AND NUMBER 10 East Street</p> <p>10f. ZIP CODE N/A</p> <p>10g. CITIZEN OF WHAT COUNTRY? Perm. Resident, USA</p> <p>11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</p> <p>12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES</p> <p>13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Black</p> <p>14. RACE — American Indian, Black, White, etc. Specify: Black</p> <p>15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) 0</p> <p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Public Health Inspector</p> <p>16b. KIND OF BUSINESS/INDUSTRY Public Health</p> <p>17. FATHER'S NAME (First, Middle, Last) Percival McIntyre</p> <p>18. MOTHER'S NAME (First, Middle, Maiden Surname) Daisy Evelyn</p> <p>19a. INFORMANT'S NAME (Type/Print) Kenneth G. McIntyre, Jr.</p> <p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32414 Crown Valley Pkwy., Dana Point, CA 92629</p> <p>20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</p> <p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Denbigh Maypen Cemetery</p> <p>20c. LOCATION — City or Town, State 6/14 Jamaica, West Indies</p> <p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. McLean</i></p> <p>22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904</p> <p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pancreatic Cancer</i></p> <p>Approximate Interval Between Onset and Death 2wks</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></p> <p>24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide</p> <p>28a. DATE OF INJURY (Month, Day, Year)</p> <p>28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>28d. DESCRIBE HOW INJURY OCCURED</p> <p>28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)</p> <p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric A. Orstam MD</i></p> <p>29c. LICENSE NUMBER D24564</p> <p>29d. DATE SIGNED (Month, Day, Year) ► 6/2/95</p> <p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Eric A. Orstam MD 2730 University Blvd W #216 Wheaton, Md</i></p> <p>31. DATE FILED (Month, Day, Year) JUN 06 1995</p> <p>32. REGISTRAR'S SIGNATURE <i>Juliann Parkoff</i></p>			



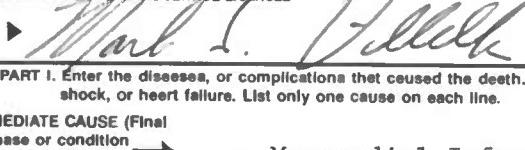
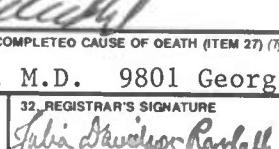
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

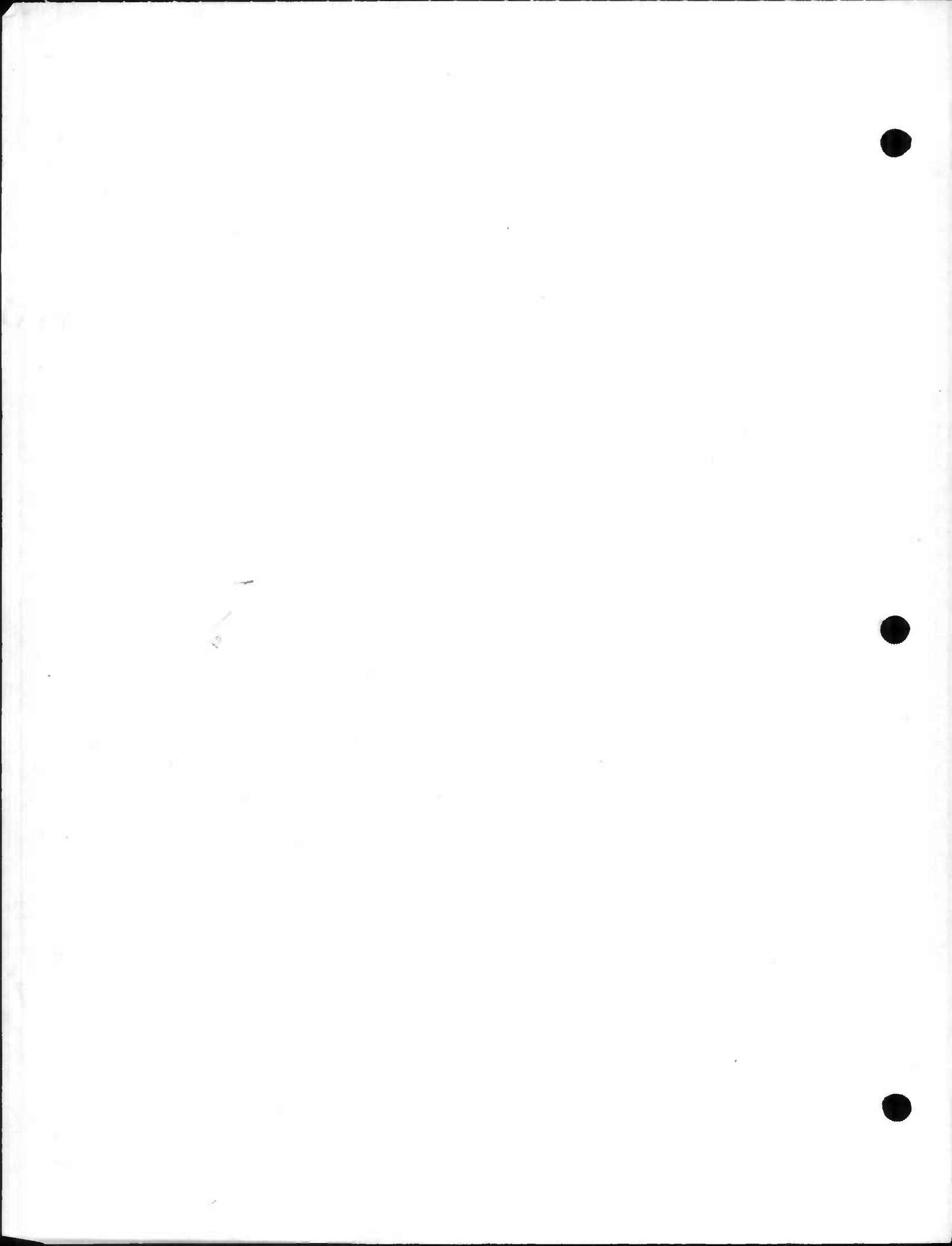
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 95 19108
1. DECEASED'S NAME (First, Middle, Last) Jeanne Ivey Measday						2. DATE OF DEATH MONTH May DAY 31 YEAR 1995		3. TIME OF DEATH 9:30 p.m.
4. SOCIAL SECURITY NUMBER 219-07-5585		5. SEX M	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) July 8, 1920		8. BIRTHPLACE (State or Foreign Country) New York
9a. FACILITY NAME (If not institution, give street and number) MedBridge Medical Rehabilitation						9b. CITY, TOWN OR LOCATION OF DEATH Wheaton		9c. COUNTY OF DEATH Montgomery
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION College Park				10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
10e. STREET AND NUMBER 6902 Dartmouth Avenue				10f. ZIP CODE 20740		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		12. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES System Service Representative		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) System Service Representative		16b. KIND OF BUSINESS/INDUSTRY IBM				
17. FATHER'S NAME (First, Middle, Last) William T. Ivey		18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Schriner						
19a. INFORMANT'S NAME (Type/Print) Walter S. Measday		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6902 Dartmouth Avenue College Park, Maryland 20740						
20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		DATE 6/5/95		20c. LOCATION — City or Town, State Silver Spring, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc.		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarct DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Diabetes Mellitus DUE TO (OR AS A CONSEQUENCE OF): d. Multiple Contractures DUE TO (OR AS A CONSEQUENCE OF):				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus, Multiple Contractures						24a. WAS AN AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <input type="checkbox"/>						
27. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. LICENSE NUMBER D 02338		29d. DATE SIGNED (Month, Day, Year) June 2, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard P. Delaney, M.D. 9801 Georgia Avenue #1-09 Silver Spring, Maryland 20902						31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

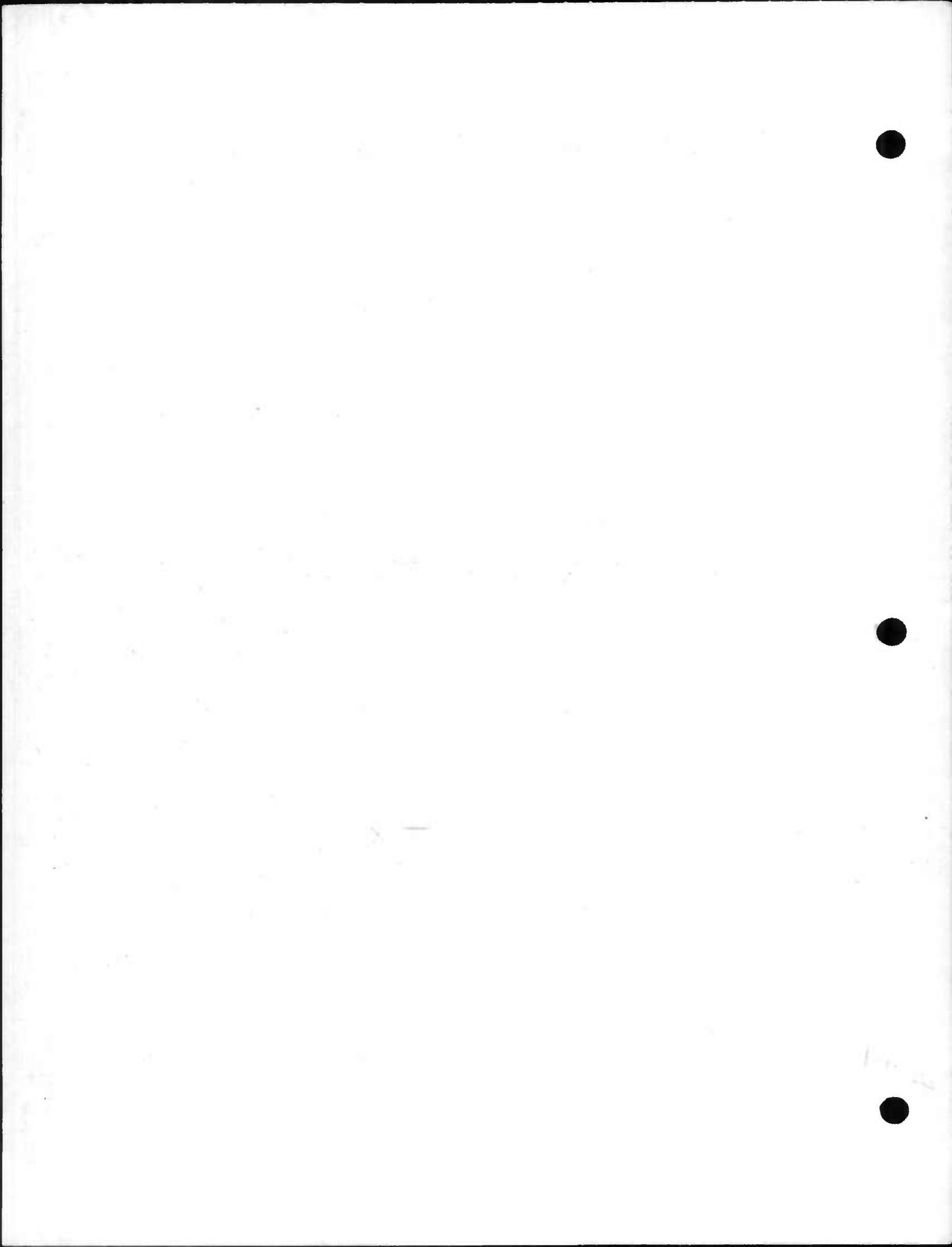
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 95 19109											
<p>1. DECEDENT'S NAME (First, Middle, Last) FELIX Webster MC BRYDE</p> <p>4. SOCIAL SECURITY NUMBER 5. SEX 6. AGE (In yrs. last birthday) 7. IF UNDER 1 YEAR 8. IF UNDER 24 HRS.</p> <p>578-32-3999 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F 87 YRS. MONTHS DAYS HOURS MIN.</p> <p>9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital 9b. CITY, TOWN OR LOCATION OF DEATH Bethesda 9c. COUNTY OF DEATH Montgomery</p> <p>RESIDENCE OF DECEDENT</p> <p>10a. STATE Maryland 10b. COUNTY Montgomery 10c. CITY, TOWN OR LOCATION Potomac 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>10e. STREET AND NUMBER 10f. ZIP CODE 10g. CITIZEN OF WHAT COUNTRY?</p> <p>10100 Falls Road 20854 United States</p> <p>11. MARITAL STATUS 12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced IF YES, GIVE WAR OR DATES 1920-</p> <p>13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White</p> <p>14. RACE — American Indian, Black, White, etc. Specify:</p> <p>15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+</p> <p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Geographer/Cartographer 16b. KIND OF BUSINESS/INDUSTRY Federal Government</p> <p>17. FATHER'S NAME (First, Middle, Last) John McLaren McBryde 18. MOTHER'S NAME (First, Middle, Maiden Surname) Flora Webster</p> <p>19a. INFORMANT'S NAME (Type/Print) Frances McBryde 19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10100 Falls Road, Potomac, Maryland 20854</p> <p>20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) June 5, 1995 DATE Montgomery Crematorium, Inc. 20c. LOCATION — City or Town, State Bethesda, Maryland</p> <p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michelle P. Knutson</i> M00348 22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc., 7557 Wisconsin Avenue, Bethesda, MD 20814-3501</p> <p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): ACUTE</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE INDEFINITE</p> <p>c. INCARCERATED HERNIA WITH SEPSIS 24 HRS</p> <p>d. FRACTURE LEFT HIP RIGHT ARM 14 DAY</p> <p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></p> <p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide</p> <p>28a. DATE OF INJURY (Month, Day, Year) May 21 1995 28b. TIME OF INJURY AM 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED FELL AT HOME</p> <p>28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) HOME 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10</p> <p>29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis C. Maylo</i> 29c. LICENSE NUMBER DO 7099 29d. DATE SIGNED (Month, Day, Year) JUNE 4 95</p> <p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAYLO 10215 FERNWOOD RD BETHESDA MD 20817 106</p> <p>31. DATE FILED (Month, Day, Year) JUN 06 1995 32. REGISTRAR'S SIGNATURE <i>Julia Dawson-Randall</i></p>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

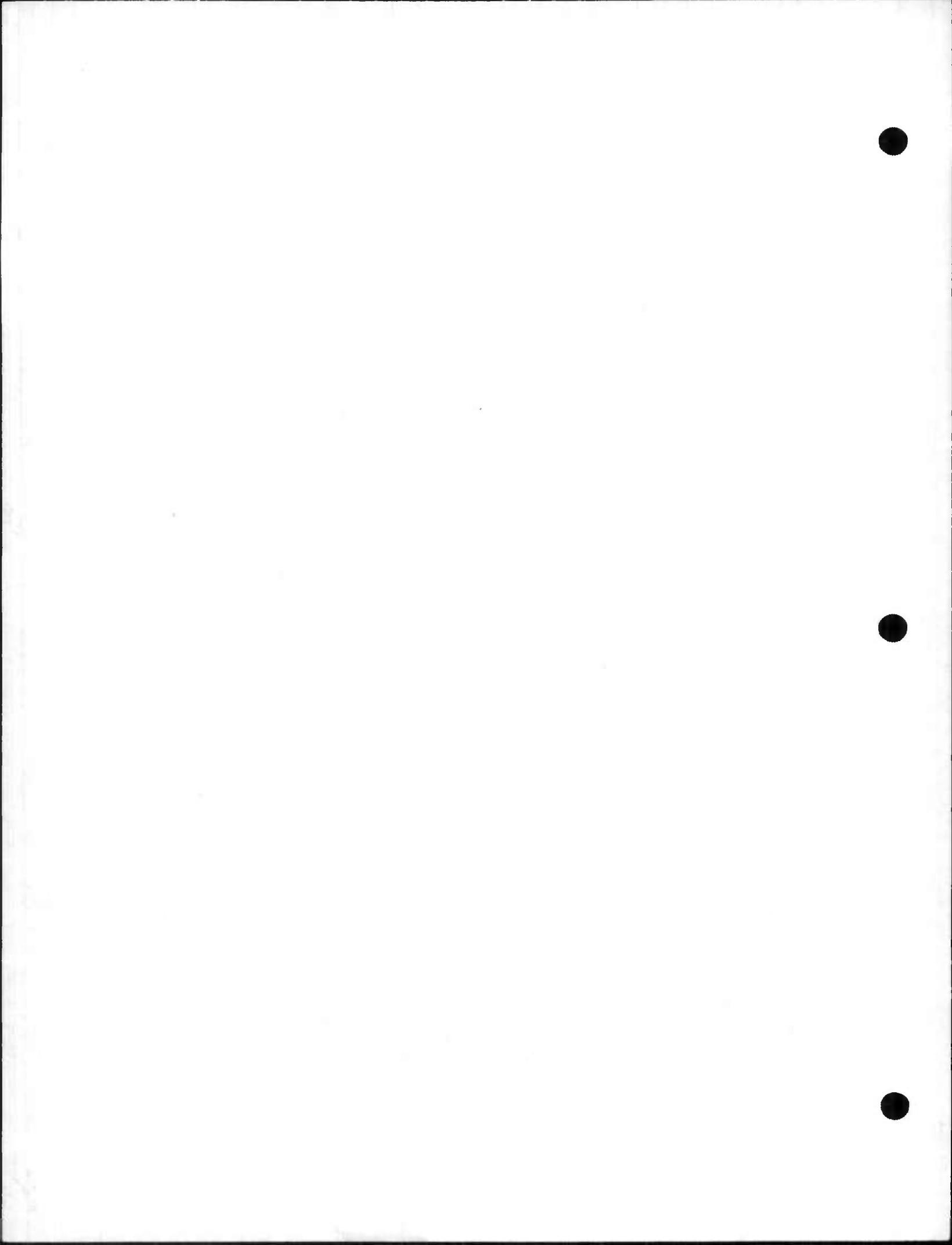
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) <i>MARIETTA E. MILLS</i>											2. DATE OF DEATH MONTH DAY YEAR <i>MAY 30 1995</i>	3. TIME OF DEATH YEAR <i>630 pm</i>
4. SOCIAL SECURITY NUMBER <i>220-18-3427</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. <i>82</i>	IF UNDER 1 YEAR MONTHS DAYS <i></i>	IF UNDER 24 HRS. HOURS MIN. <i></i>	7. DATE OF BIRTH (Month, Day, Year) <i>Feb 7 1913</i>	8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Lorien Nursing Home</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Columbia</i>			9c. COUNTY OF DEATH <i>Howard</i>					
RESIDENCE OF DECEDENT												
10a. STATE <i>Maryland</i>	10b. COUNTY <i>Howard</i>	10c. CITY, TOWN OR LOCATION <i>Columbia</i>						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <i>6334 Cedar Lane</i>				10f. ZIP CODE <i>21044</i>			10g. CITIZEN OF WHAT COUNTRY? <i>United States</i>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Laboratory Assistant</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Research Hospital</i>							
17. FATHER'S NAME (First, Middle, Last) <i>Joseph Walter Mills</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Bertie West</i>								
19a. INFORMANT'S NAME (Type/Print) <i>Helen V. Crown</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>400 Dogwood Drive, Gaithersburg, Maryland 20877</i>								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <i></i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Forest Oak Cemetery</i>			DATE <i>6/5</i>	20c. LOCATION — City or Town, State <i>Gaithersburg, Maryland</i>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael D. Gibbons</i>				22. NAME AND ADDRESS OF FACILITY <i>DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD. 20877</i>								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>PERITONITIS - CHEMICAL</i>											Acute	
b. DUE TO (OR AS A CONSEQUENCE OF): <i>MISPLACED GASTROSTOMY TUBE</i>											12 hours	
c. DUE TO (OR AS A CONSEQUENCE OF): <i></i>												
d. DUE TO (OR AS A CONSEQUENCE OF): <i></i>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>END STAGE MULTINFARCT DEMENTIA Cerebrovascular disease.</i>											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>LORIEN NURSING HOME</i>										
27. MANNER OF DEATH <i>Natural Accident Suicide Homicide</i>		28a. DATE OF INJURY (Month, Day, Year) <i>MAY 30 1995</i>			28b. TIME OF INJURY <i>~14 M</i>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED <i>Gastrostomy through umbilicus</i>					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>LORIEN NURSING HOME</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>6334 Cedar Lane Columbia MD</i>										
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ruthann M. Miller, PA-C</i>			29c. LICENSE NUMBER <i>031575/D31473</i>			29d. DATE SIGNED (Month, Day, Year) <i>May 30, 1995</i>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Karen D. Mills et al 9501 Old Annapolis Rd. Ellicott City MD 21043</i>		31. DATE FILED (Month, Day, Year) <i>JUN 06 1995</i>			32. REGISTRAR'S SIGNATURE <i>John J. Mulligan, Jr.</i>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

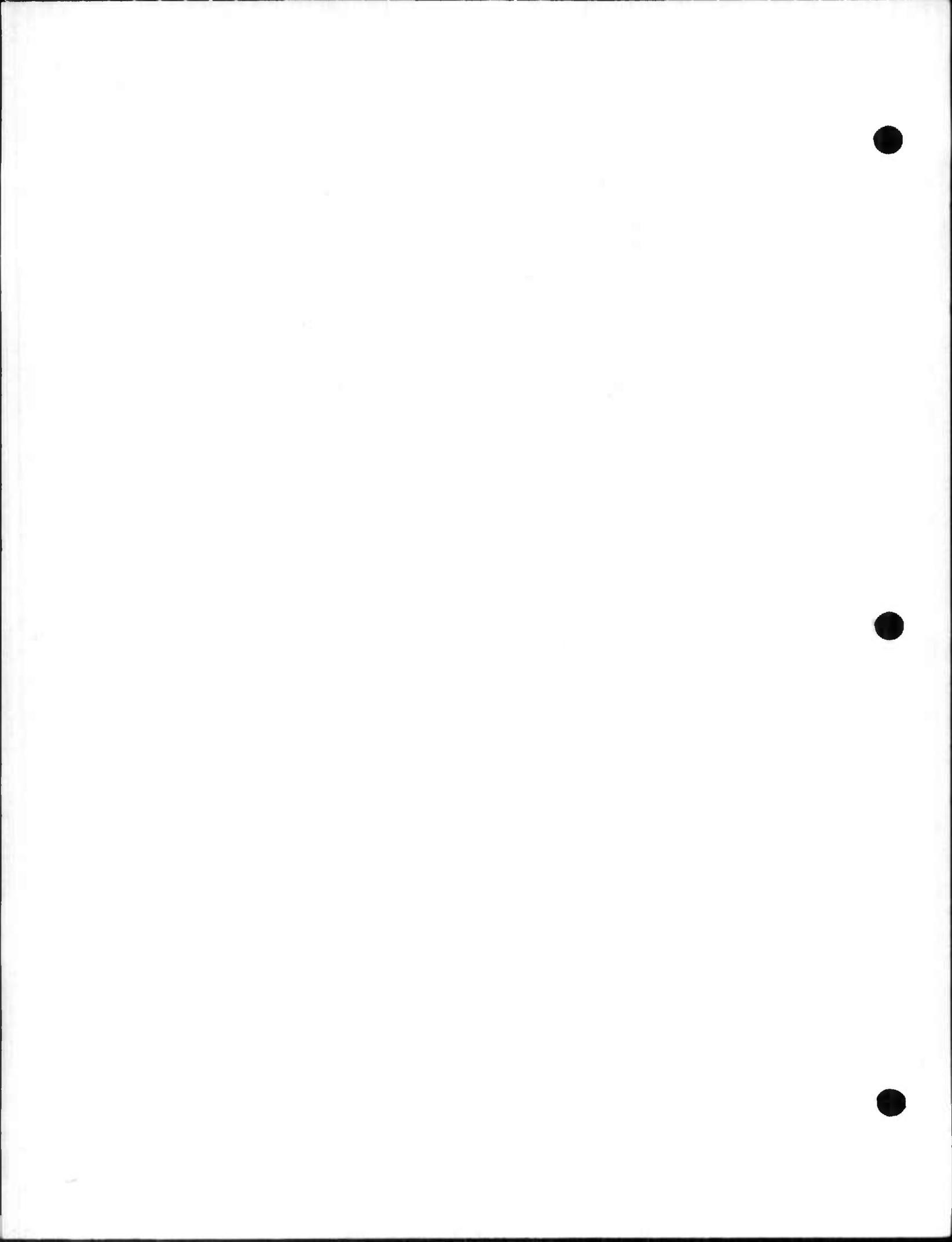
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) Helen (NMN) Mihalopoulos										2. DATE OF DEATH MONTH DAY YEAR June 1, 1995	3. TIME OF DEATH 7:30 P.M.
4. SOCIAL SECURITY NUMBER 088-01-3876		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 28, 1901		8. BIRTHPLACE (State or Foreign Country) Greece	
9a. FACILITY NAME (If not institution, give street and number) Collingswood Nursing Center										9b. CITY, TOWN OR LOCATION OF DEATH Rockville	9c. COUNTY OF DEATH Montgomery
RESIDENCE OF DECEASED 10a. STATE Maryland 10b. COUNTY Montgomery 10c. CITY, TOWN OR LOCATION Rockville										10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 199 Rollins Avenue										10f. ZIP CODE 20852	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMEED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)				16b. KIND OF BUSINESS/INDUSTRY homemaker				own home	
17. FATHER'S NAME (First, Middle, Last) Elias Polymenakos										18. MOTHER'S NAME (First, Middle, Maiden Surname) Antonia Tirovillas	
19a. INFORMANT'S NAME (Type/Print) Theodore S. Michaels										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11412 Rolling House Rd., Rockville, Md. 20852	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) The Woodlawn Cemetery				DATE June 7, 95	20c. LOCATION — City or Town, State Bronx, New York				
<i>John T. Michaels</i>					22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home						
					22. NAME AND ADDRESS OF FACILITY 2222 Wisconsin Ave., N.W., Wash., DC 20007						
23. Part I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction										Approximate Interval Between Onset and Death Immediate	
b. _____ c. _____ d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED _____						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) At home							
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29f. SIGNATURE AND TITLE OF CERTIFIER Stephen T. Michaels, M.D.										29g. LICENSE NUMBER D42845	29h. DATE SIGNED (Month, Day, Year) ► June 1, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen T. Michaels, M.D., 8830 Cameron St., Silver Spring, Md. 20910											
31. DATE FILED (Month, Day, Year) JUN 06 1995										32. REGISTRAR'S SIGNATURE Julia Shuster-Kerstall	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

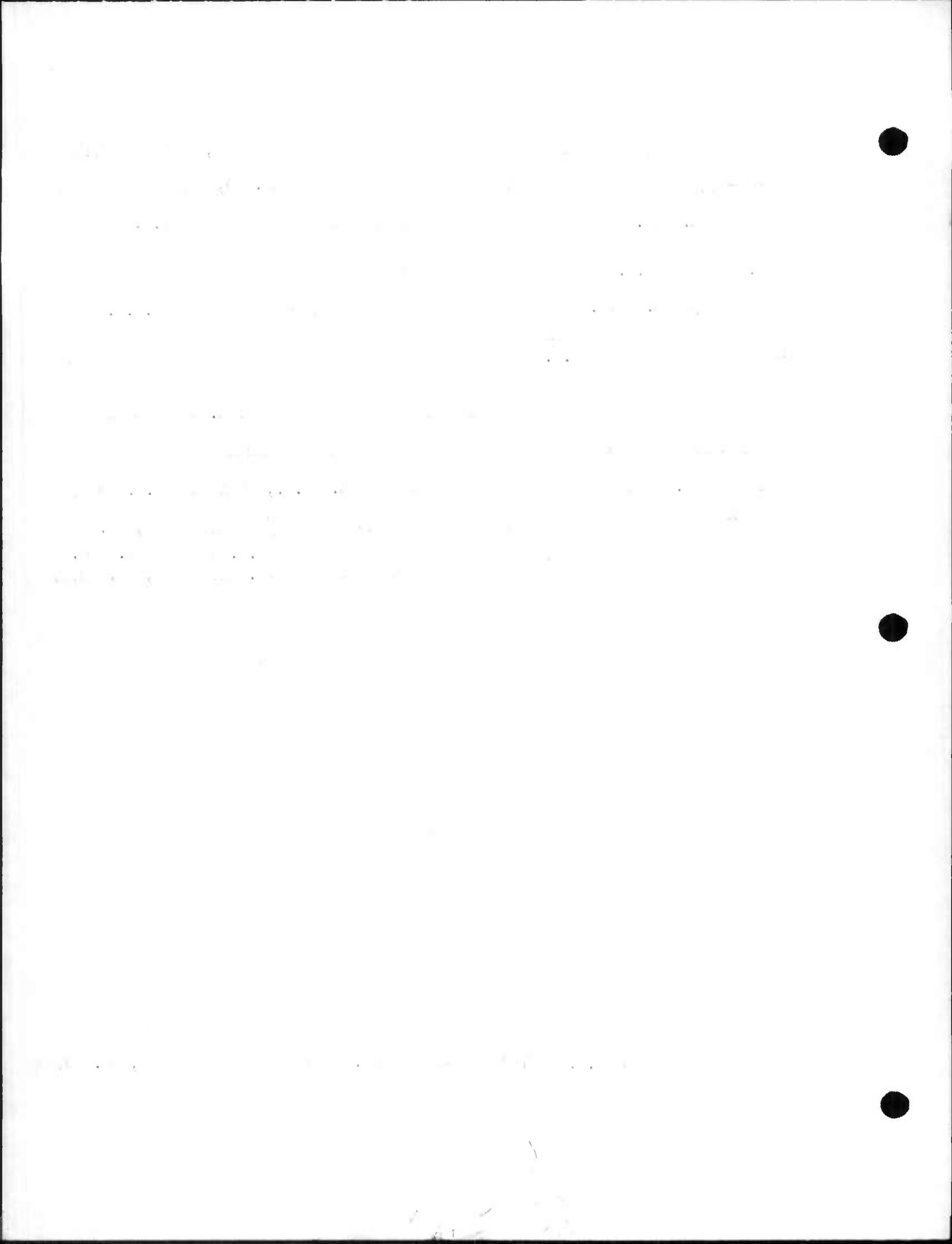
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										3. TIME OF DEATH	
PAUL FRANCIS MORAN												JUNE 8, 1995 07:45 A M	
4. SOCIAL SECURITY NUMBER 186-14-4572		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 30, 1916		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9e. FACILITY NAME (If not institution, give street and number) 9524 51st. Ave.		9b. CITY, TOWN OR LOCATION OF DEATH College Park										9c. COUNTY OF DEATH P.G.	
RESIDENCE OF DECEDENT 10a. STATE MD.		10b. COUNTY P.G.		10c. CITY, TOWN OR LOCATION College Park								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STREET AND NUMBER 9524 51 st. Ave.						10i. ZIP CODE 20740				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+ Librarian				16b. KIND OF BUSINESS/INDUSTRY Dept. of Interior							
17. FATHER'S NAME (First, Middle, Last) Patrick Moran		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary McNish											
19a. INFORMANT'S NAME (Type/Print) Kathleen M. Krivak		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1404 Monroe St. N.E., Washington D.C. 20017											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chambers Crematory				DATE 6/9		20c. LOCATION — City or Town, State Riverdale, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas S. Chambers		22. NAME AND ADDRESS OF FACILITY W.W. Chambers Co. Inc. 5801 Cleveland Ave. Riverdale, MD. 20737											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>INTRACRANIAL METASTATIC CANCER</i>												Approximate Interval Between Onset and Death 1 month	
b. <i>METASTATIC LUNG CANCER</i>												2 yrs	
c. <i></i>													
d. <i></i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) ✓ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Parkhurst M.D. 7305 Baltimore Ave. Suite 107 College Park, MD. 20740		32. REGISTRAR'S SIGNATURE John Shadwell-Robell				31. DATE FILED (Month, Day, Year) JUN 09 1995				33. DATE SIGNED (Month, Day, Year) June 8, 1995			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

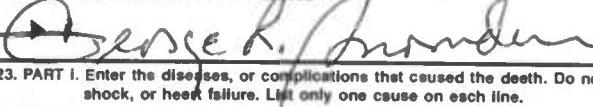
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

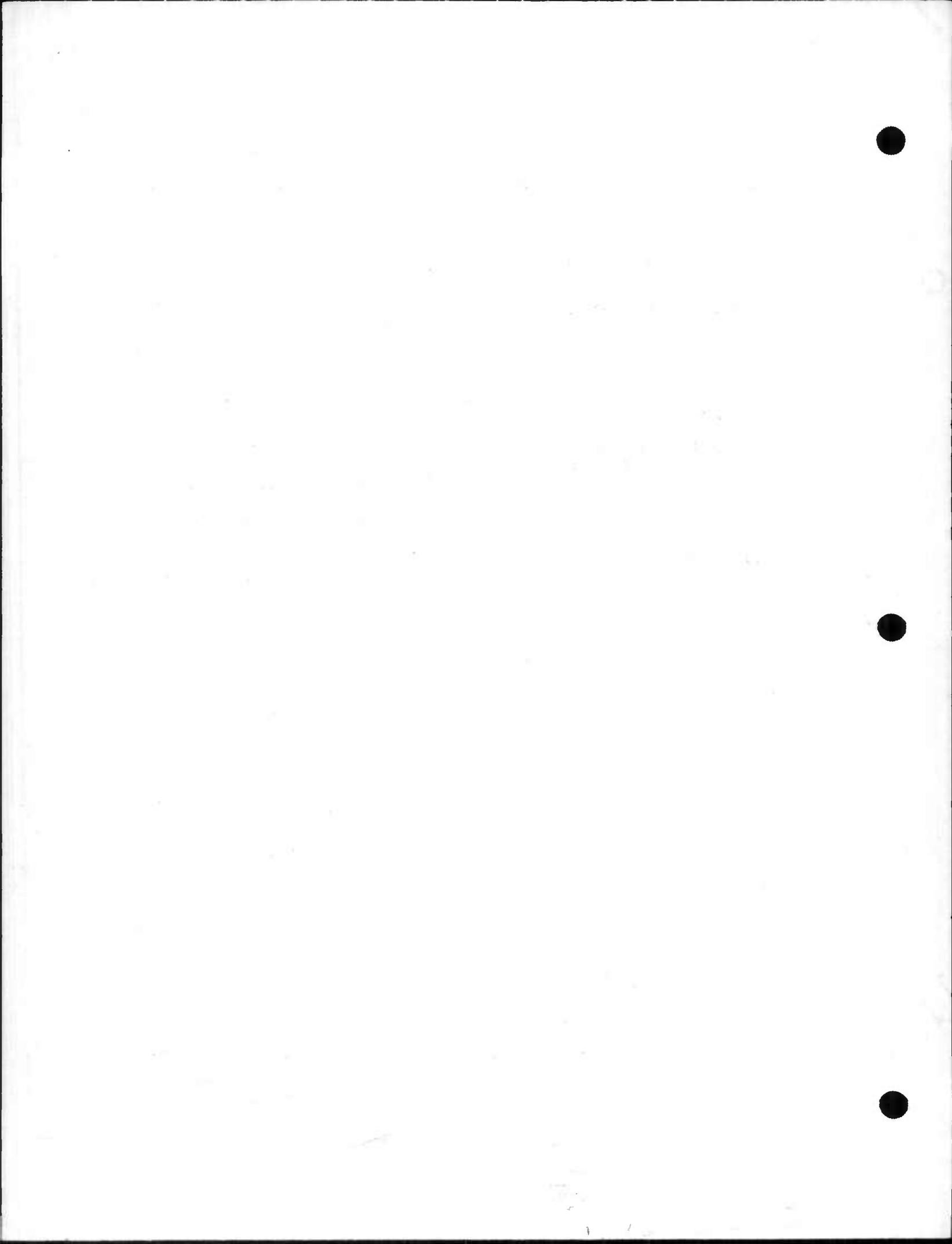
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) FRANK A. MYERS										2. DATE OF DEATH MONTH DAY YEAR JUNE 07 95	3. TIME OF DEATH 6:00 p.m.
4. SOCIAL SECURITY NUMBER 219-10-4417		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan 6, 1919	8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) Saint Agnes Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Baltimore				
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Olney			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 3373 Tidewater Court				10f. ZIP CODE 20832		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Janitorial			16b. KIND OF BUSINESS/INDUSTRY Vitro-Lab.						
17. FATHER'S NAME (First, Middle, Last) George A. Myers				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena Powell							
19a. INFORMANT'S NAME (Type/Print) (Wife) Mrs Lillian Y. Myers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3206 Spartan Rd, #14, Olney, Md #20832							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parker Cemetery			DATE 6/13		20c. LOCATION — City or Town, State Cooksville, Md				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Snowden Funeral Home P.A. 20850 246 N/Washington St., Rockville, Md							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. URO SEPSIS DUE TO (OR AS A CONSEQUENCE OF): b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): c. COPD DUE TO (OR AS A CONSEQUENCE OF): d.										4 DAYS	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. b. c. d.										2 DAYS	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTI INFARCT DEMENTIA (5 YEARS)										Approximate Interval Between Onset and Death 10 YEARS	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER 6020		29d. DATE SIGNED (Month, Day, Year) ► JUNE. 07, 95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GILBERT CHODAC, SAINT AGNES HOSPITAL, 900 CATON AVE, BALTIMORE, MD, 21229											
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

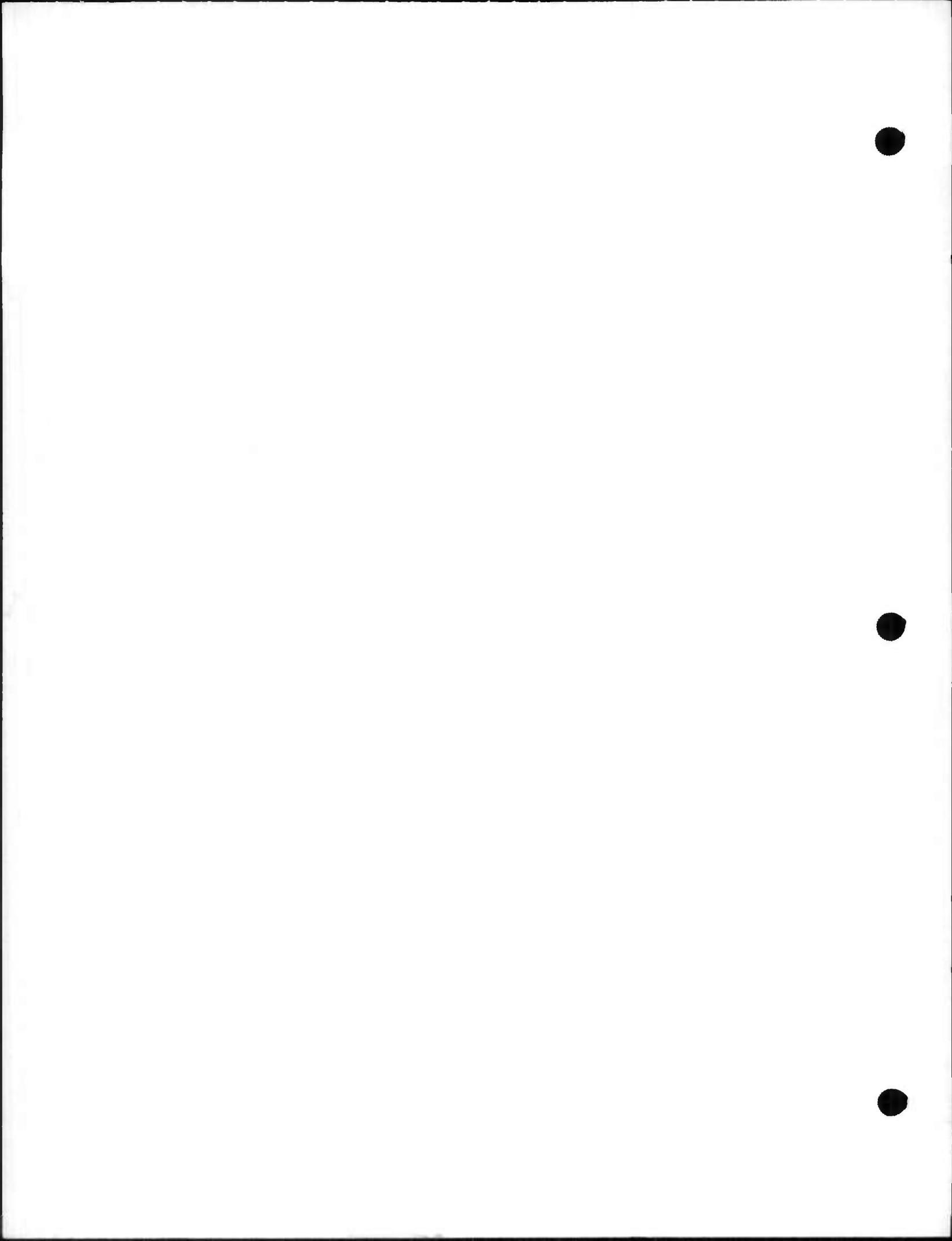
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)											
GLENN W. MYERS											
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2. DATE OF DEATH			3. TIME OF DEATH
220-10-7381		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	73 YRS.	MONTH	DAY	MONTH	DAY	MONTH	DAY	YEAR	5:00 A M
9a. FACILITY NAME (If not institution, give street and number)										7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
Memorial Hospital										Aug 30, 1921	MD
RESIDENCE OF DECEDENT										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
10a. STATE		10b. COUNTY		Cumberland						Allegany	
MD				Baltimore City							
10c. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1213 Light Street										21230	USA
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)		Former Owner				Myers Cleaners					
College (1-4 or 5 +)											
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
James C. Meyers										Cora V. (Johnston)	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Helen M. Meyers										139 Humbird Street; Cumberland, MD 21502	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
		Maryland Veterans Cemetery				06/06		Flintstone, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										22. NAME AND ADDRESS OF FACILITY	
<i>Jones J Scarpelli</i>										Scarpelli Funeral Home Cumberland, MD 21502	
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure										2 weeks	
b. Coronary Artery Disease										Unknown	
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)									
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								OTHER:	
27. MANNER OF DEATH		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death from natural causes		3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Death from suicide		4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined					
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Johnston</i>		29c. LICENSE NUMBER								29d. DATE SIGNED (Month, Day, Year)	
Dr. V. Poonai 955 Frederick Street, Cumberland, MD 21502		D 36766								June 3, 1995	
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE <i>Jane Anderson-Randall</i>									



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

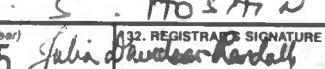
TO BE COMBINED BY FINEBAL DIRECTOR

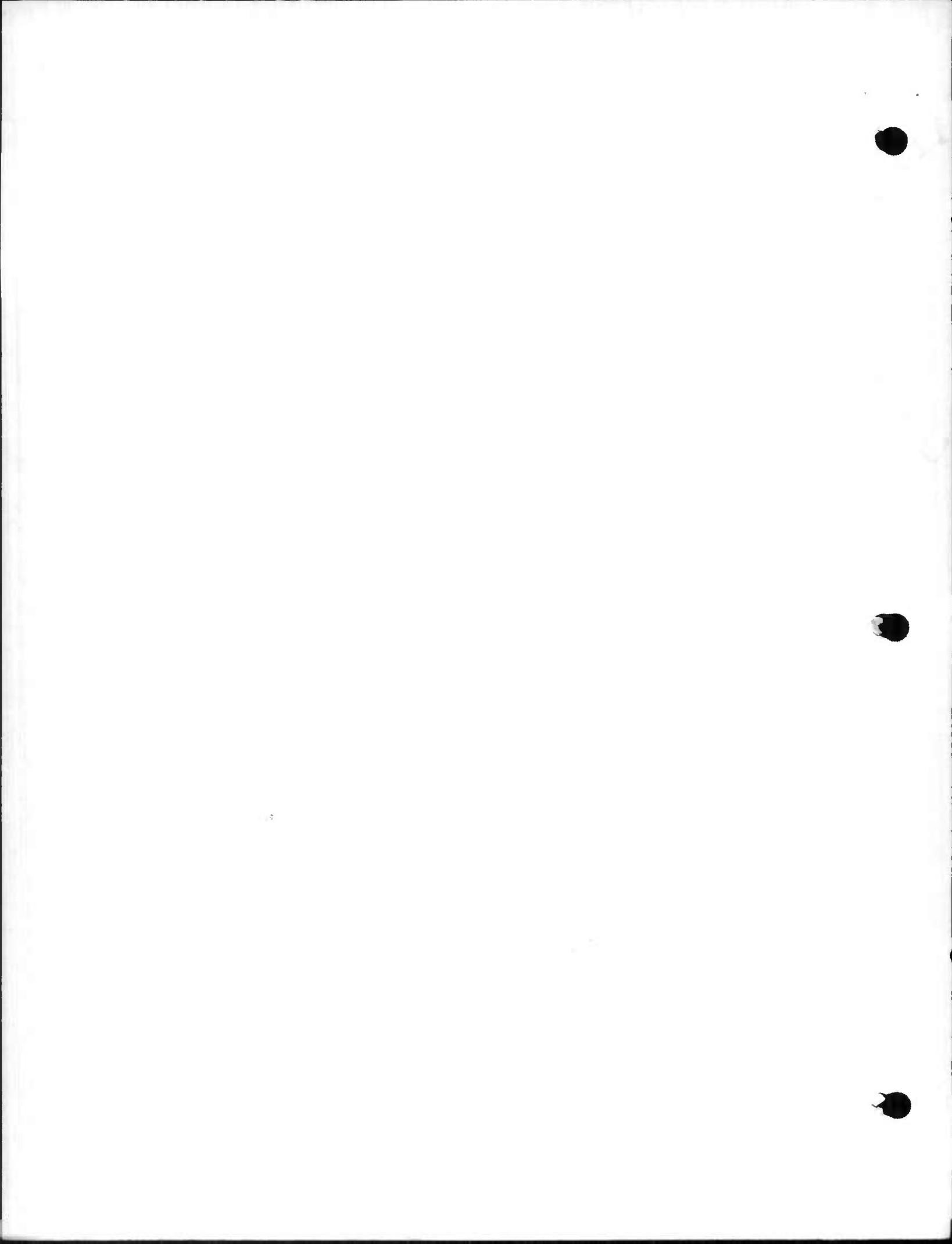
**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

**1 - FOR
STATE
REGISTRATION**

REG. NO

95 19115

TO BE COMPLETED BY FUNERAL DIRECTOR						CERTIFICATE OF DEATH				REG. NO.							
<p>1. DECEDENT'S NAME (First, Middle, Last) DAVID CHARLES MILLER</p> <p>4. SOCIAL SECURITY NUMBER 213-24-7823</p> <p>5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>6. AGE (In yrs. last birthday) 66 YRS.</p> <p>7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.</p>						2. DATE OF DEATH MONTH DAY YEAR JUN 10 1995		3. TIME OF DEATH 8:55 P.M.									
<p>9e. FACILITY NAME (If not Institution, give street and number) Carroll County General Hospital</p> <p>RESIDENCE OF DECEDENT</p> <p>10a. STATE Maryland</p> <p>10b. COUNTY Carroll</p> <p>10c. CITY, TOWN OR LOCATION Finksburg</p>						9b. CITY, TOWN OR LOCATION OF DEATH Westminster		9c. COUNTY OF DEATH Carroll									
<p>10e. STREET AND NUMBER 2138 Bethel Road</p>						10f. ZIP CODE 21048		10g. CITIZEN OF WHAT COUNTRY? United States									
<p>11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p>			<p>12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO If yes, give war or dates Korean Conflict</p>			<p>13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: white</p>			14. RACE — American Indian, Black, White, etc. Specify:								
<p>15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8</p>			<p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) service manager</p>			<p>16b. KIND OF BUSINESS/INDUSTRY auto repair</p>											
<p>17. FATHER'S NAME (First, Middle, Last) David Roscoe Miller</p>						<p>18. MOTHER'S NAME (First, Middle, Maiden Surname) Winnie Davis</p>											
<p>19a. INFORMANT'S NAME (Type/Print) Beulah Leppo Miller</p>						<p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2138 Bethel Road, Finksburg, MD 21048</p>											
<p>20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)</p>			<p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremations Inc.</p>			<p>20c. LOCATION — City or Town, State Hampstead, MD</p>											
<p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE </p>						<p>22. NAME AND ADDRESS OF FACILITY Pritts Funeral Home & Chapel 412 Washington Rd., Westminster, MD</p>											
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>End stage Heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes</i></p> <p>b. <i>Diabetes</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Cardiac arrhythmia</i></p> <p>c. <i>Cardiac arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Pulmonary fibrosis</i></p> <p>d. <i>Pulmonary fibrosis</i></p>																	
<p>Approximate Interval Between Onset and Death</p> <p>3 yrs. // // //</p>																	
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p>																	
						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
<p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></p>																	
<p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>		<p>26. PLACE OF DEATH (Check only one)</p> <p>HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p>															
<p>27. MANNER OF DEATH</p> <table border="0"> <tr> <td><input checked="" type="checkbox"/> Natural</td> <td><input type="checkbox"/> Pending Investigation</td> </tr> <tr> <td><input type="checkbox"/> Accident</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Suicide</td> <td><input type="checkbox"/> Could not be determined</td> </tr> <tr> <td><input type="checkbox"/> Homicide</td> <td></td> </tr> </table>		<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending Investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide		<p>28a. DATE OF INJURY (Month, Day, Year)</p>		<p>28b. TIME OF INJURY M</p>		<p>28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>28d. DESCRIBE HOW INJURY OCCURED</p>	
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending Investigation																
<input type="checkbox"/> Accident																	
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																
<input type="checkbox"/> Homicide																	
<p>28e. PLACE OF INJURY — At home, term, street, tectory, office building, etc. (Specify)</p>		<p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p>															
<p>29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p><input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p>																	
<p>29b. SIGNATURE AND TITLE OF CERTIFIER </p>						29c. LICENSE NUMBER J 39502		29d. DATE SIGNED (Month, Day, Year) ► 6/11/95									
<p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)</p> <p>S. Roscoe Miller (aw) Co-Sen-Hosp</p>																	
<p>31. DATE FILED (Month, Day, Year) JUN 12 1995</p>		<p>32. REGISTRAR'S SIGNATURE </p>															



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

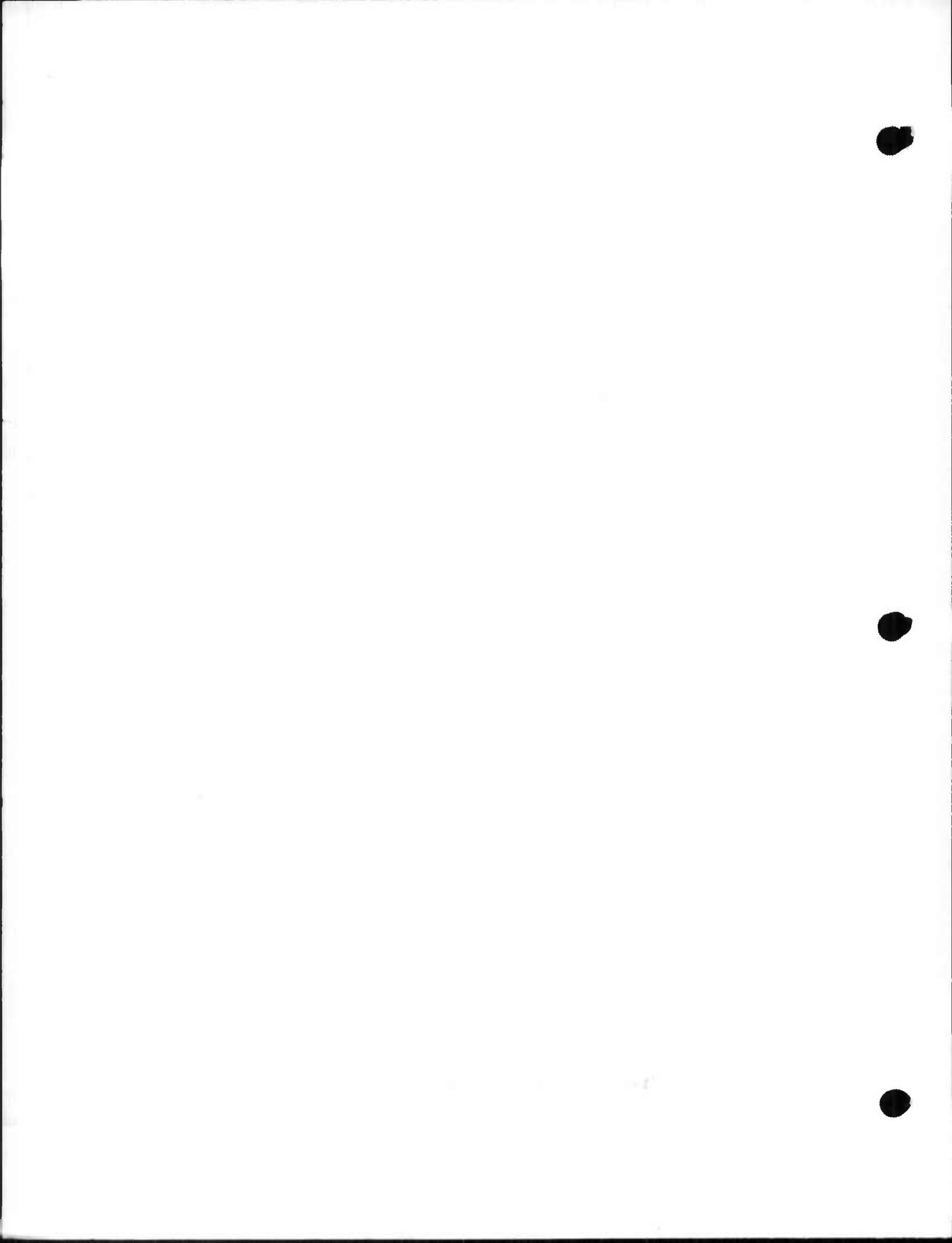
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR										95 19116	
1. DECEASED'S NAME (First, Middle, Last) PEARL ELLEN MILLER										2. DATE OF DEATH MONTH DAY YEAR June 1, 1995	3. TIME OF DEATH 11:00P. M
4. SOCIAL SECURITY NUMBER 220-58-1003		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) March 11, 1913		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) Memorial Hospital & Medical Center										9b. CITY, TOWN OR LOCATION OF DEATH Cumberland	9c. COUNTY OF DEATH Allegany
10a. STATE WV		10b. COUNTY Hampshire		10c. CITY, TOWN OR LOCATION Romney				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER HC 81, Box 122 B		10f. ZIP CODE 26757				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) Charles E. Timbrook										18. MOTHER'S NAME (First, Middle, Maiden Surname) Nora Hott	
19a. INFORMANT'S NAME (Type/Print) Evelyn E. Spencer		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 1, Box 275 A, Ridgely, WV 26753									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Ebenezer Cemetery		20b. PLACE AND DATE OF DISPOSITION /Name of Cemetery, crematory or other place/ Ebenezer Cemetery				DATE June 4, 1995	20c. LOCATION — City or Town, State Romney, WV				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Shaffer Funeral Home, Inc. 230 East Main St., Romney, WV 26757	
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myeloproliferative Disorder DUE TO (OR AS A CONSEQUENCE OF):										Two Months	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Congestive Heart Failure.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Oupatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 14865				29d. DATE SIGNED (Month, Day, Year) ► June 2, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. R. Barrera, Memorial Hospital, Medical Building, Cumberland, MD 21502											
31. DATE FILED (Month, Day, Year) JUN 9 1995		32. REGISTRAR'S SIGNATURE 									



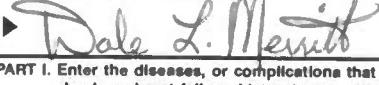
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

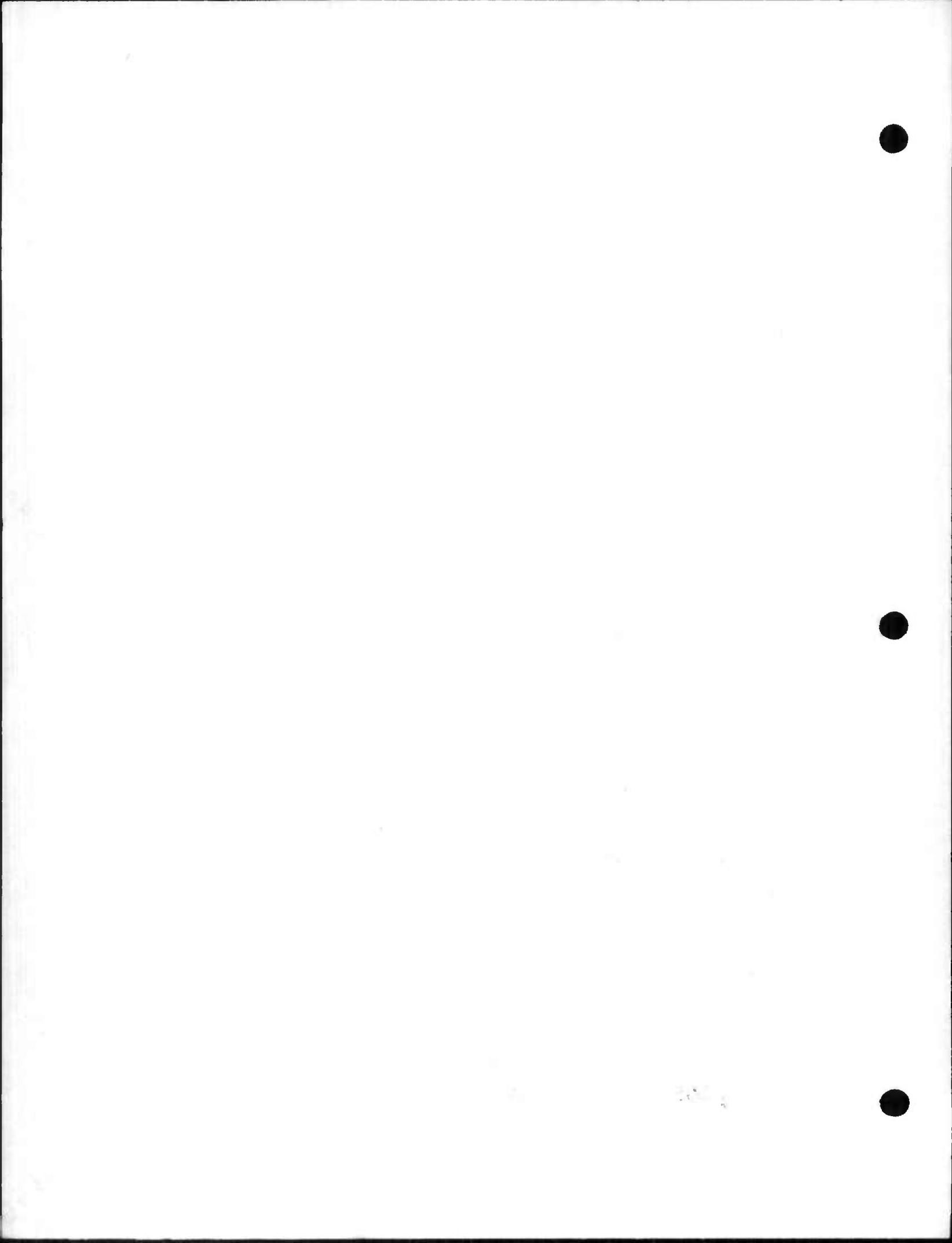
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

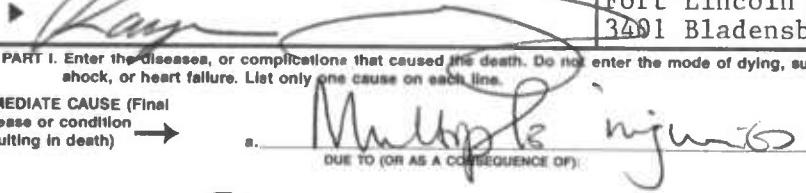
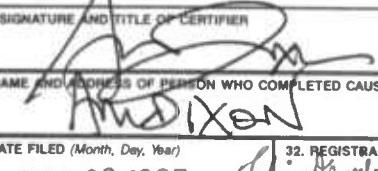
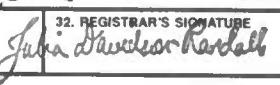
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH			
GRACE RUTH MILLER											JUNE 8, 1995	09:12 A M			
4. SOCIAL SECURITY NUMBER 214-05-8318		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC 29 1905	8. BIRTHPLACE (State or Foreign Country) MARYLAND								
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY									
RESIDENCE OF DECEASED															
10a. STATE MARYLAND	10b. COUNTY ALLEGANY	10c. CITY, TOWN OR LOCATION LAVALE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 15 NORTH WOODLAWN AVENUE					10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.								
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) CLERK-DEPT. STORE			16b. KIND OF BUSINESS/INDUSTRY CLERK/RETAIL										
17. FATHER'S NAME (First, Middle, Last) WILLIAM D. MILLER					18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY FLORENCE RUNKLES										
19a. INFORMANT'S NAME (Type/Print) CHARLYNNE MERRITT					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 N. WOODLAWN AVE. LAVALE MARYLAND 21502										
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION /Name of Cemetery, Cemetery, etc. ST. LUKES CEMETERY			20c. DATE JUNE 10 1995		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY MERRITT-ADAMS FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): 7 days															
b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): 1 year															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I, Pneumonia; dehydration															
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29e. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29f. DATE SIGNED (Month, Day, Year) ► JUNE 8, 1995										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. ESPINA, MD 902 SETON DRIVE, CUMB. MD					29g. LICENSE NUMBER 103459										
31. DATE FILED (Month, Day, Year) JUN 09 1995					32. REGISTRAR'S SIGNATURE Julie Davidson-Rosell										



95 19118

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DANIEL WAYNE MITCHELL												2. DATE OF DEATH MONTH DAY YEAR MAY 26, 1995	3. TIME OF DEATH 22:00 P M
4. SOCIAL SECURITY NUMBER 216-38-5756		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 52 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	8. IF UNDER 24 HRS. 0 0 0 0	9. DATE OF BIRTH (Month, Day, Year) July 8, 1942	10. BIRTHPLACE (State or Foreign Country) Virginia						
9a. FACILITY NAME (If not institution, give street and number) DOCTORS COMMUNITY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH Lanham			9c. COUNTY OF DEATH PRINCE GEORGES						
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO	
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Riverdale			10f. ZIP CODE 20737			10g. CITIZEN OF WHAT COUNTRY? United States					
10e. STREET AND NUMBER 5730 East Pine Drive													
11. MARITAL STATUS 1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES None			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction Inspector			16b. KIND OF BUSINESS/INDUSTRY Construction								
17. FATHER'S NAME (First, Middle, Last) Robert C. Mitchell				18. MOTHER'S NAME (First, Middle, Maiden Surname) June McIlwee									
19a. INFORMANT'S NAME (Type/Print) June Richards				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5730 East Pine Drive, Riverdale, Maryland 20737									
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery			20c. DATE 5/31/95			20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 												22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Multiple injuries													
b. DUE TO (OR AS A CONSEQUENCE OF): None													
c. DUE TO (OR AS A CONSEQUENCE OF): None													
d. DUE TO (OR AS A CONSEQUENCE OF): None													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 □ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 □ NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO X UNCERTAIN □													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 X ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify) ER/Outpatient											
27. MANNER OF DEATH 1 □ Natural 5 □ Pending Investigation 2 X Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year) May 26, 1995		28b. TIME OF INJURY 2130 M	28c. INJURY AT WORK? 1 □ YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURRED Driver in auto/Auto collision							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) KENILWORTH & RITTENHOUSE STS P.C. Co.											
29a. CERTIFIER (Check only one) 2 X MEDICAL EXAMINER		29c. LICENSE NUMBER OCME											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29d. DATE SIGNED (Month, Day, Year) MAY 28, 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Alexander Randall													
31. DATE FILED (Month, Day, Year) JUN 02 1995		32. REGISTRAR'S SIGNATURE 											

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

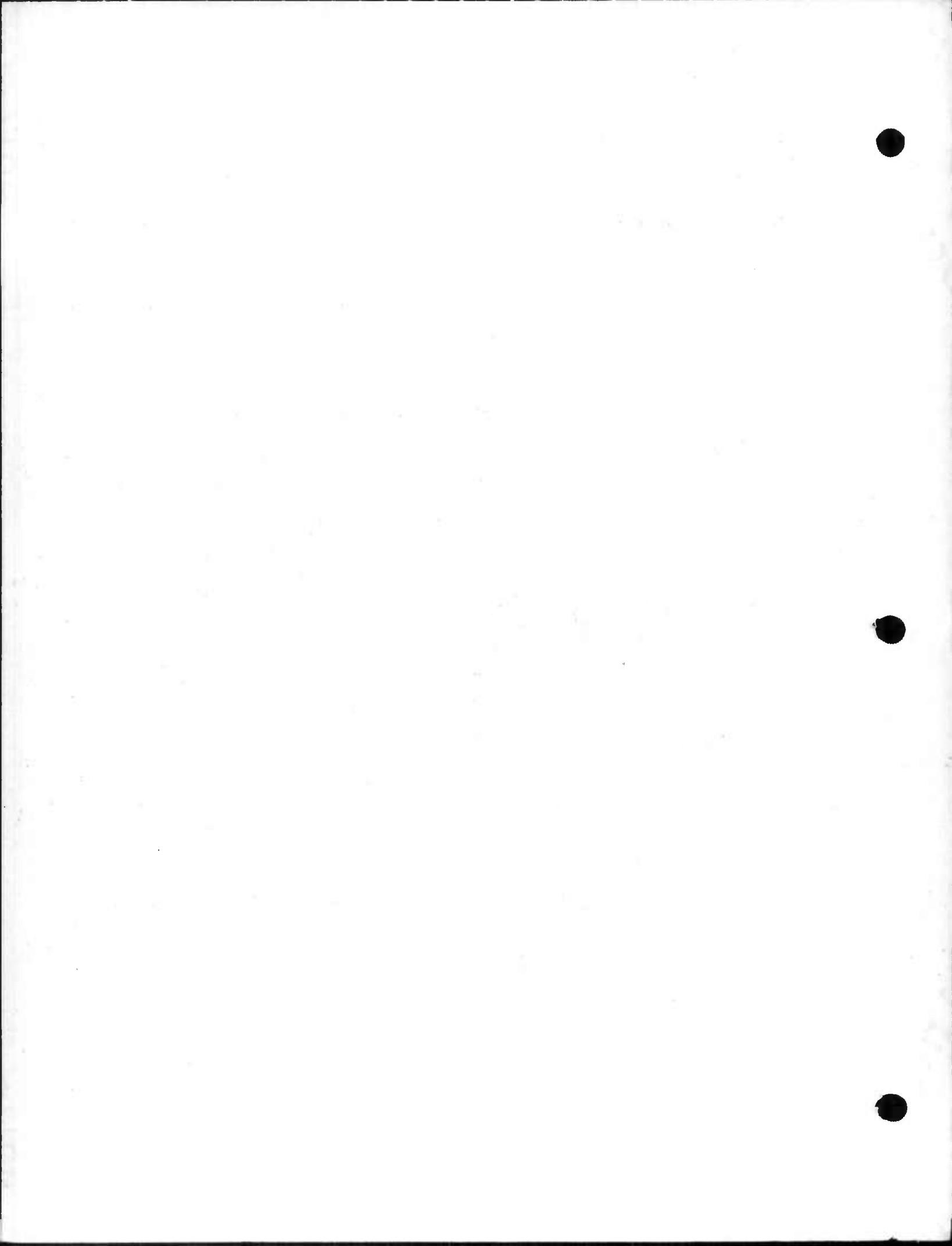
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

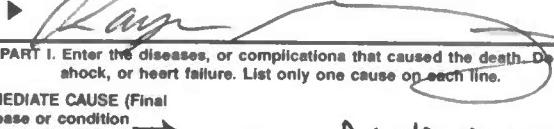
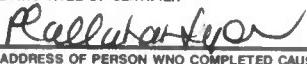
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

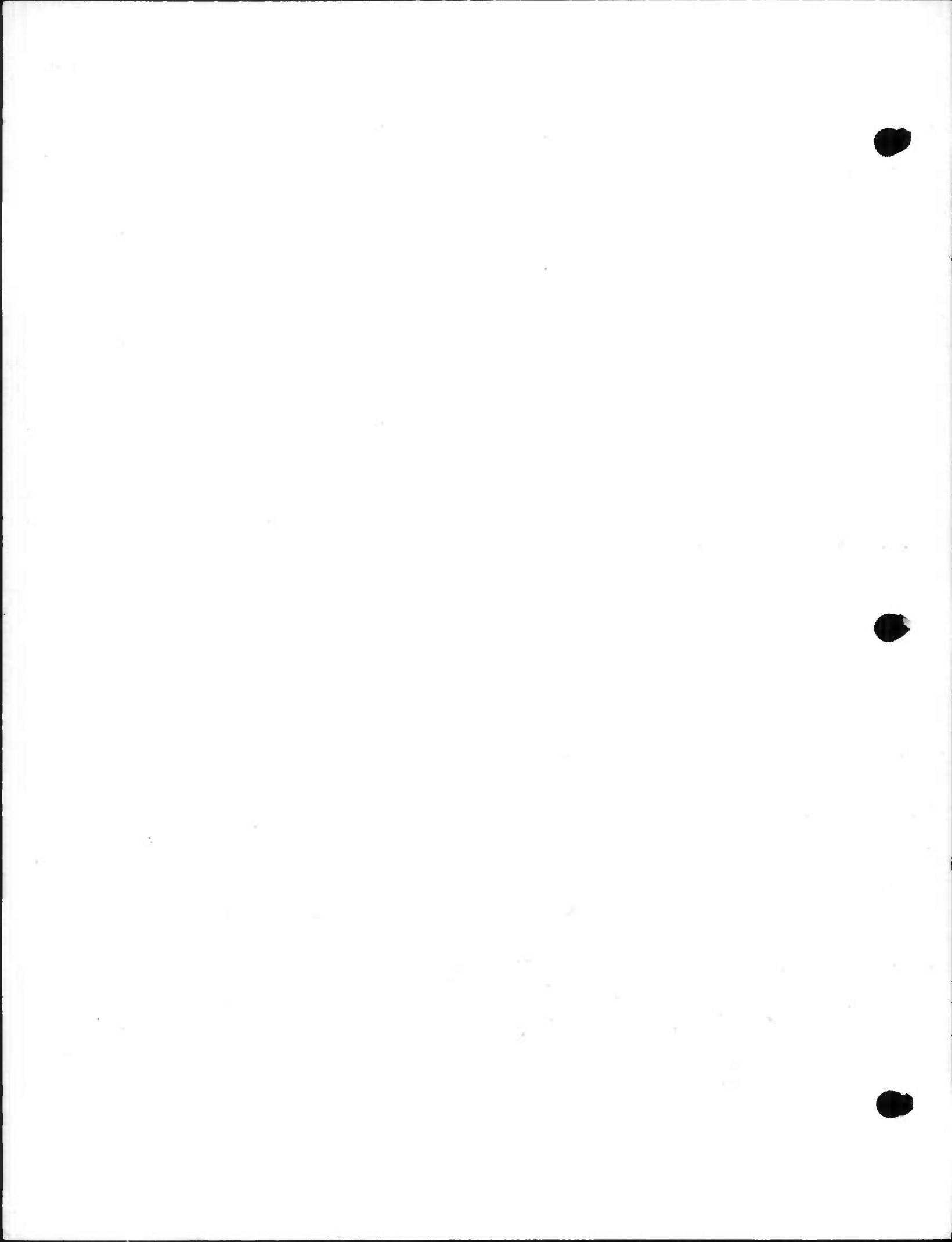
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH	
John O. Mathis		May 27, 1995								1715 M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.					
578-74-6469		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	37 YRS.	MONTHS	DAYS	HOURS	MIN.				
9a. FACILITY NAME (If not institution, give street and number)		7. DATE OF BIRTH (Month, Day, Year)								8. BIRTHPLACE (State or Foreign Country)	
Calvert Memorial Hospital		July 22, 1957								Washington, DC	
RESIDENCE OF DECEASED		9b. CITY, TOWN OR LOCATION OF DEATH								9c. COUNTY OF DEATH	
10a. STATE		10b. COUNTY		Prince Frederick						Calvert	
Maryland		Calvert County		North Beach							
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?	
P.O. Box 1367		20714								United States	
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 11		College (1-4 or 5+) Carpenter				Carpentry					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
George L. Mathis, Jr.										Annie L. Lewis	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Annie L. Carter										7704 Allentown Rd., Fort Washington, MD 20744	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery				DATE		20c. LOCATION — City or Town, State			
						5/31/95		Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate interval Between Onset and Death minutes	
a. Acute myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):											
b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hyperlipidemia Hypertension										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER D41794	29d. DATE SIGNED (Month, Day, Year) ► 5-29-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
Dr. Priscilla, Callahan-Lyon M.D., Prince Frederick Md 20678											
31. DATE FILED (Month, Day, Year) JUN 02 1995		32. REGISTRAR'S SIGNATURE 									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

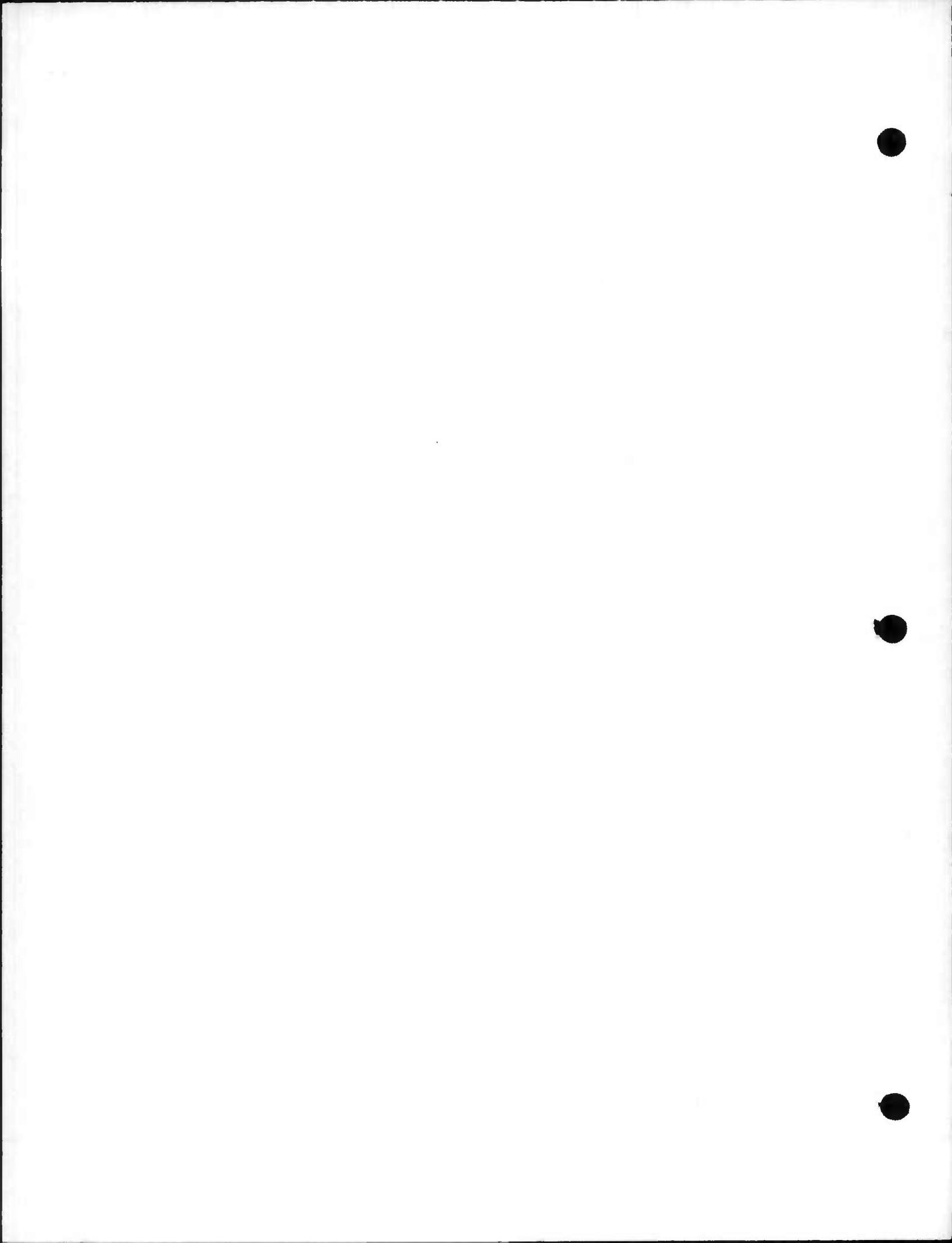
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

13

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR									3. TIME OF DEATH		
Hirschel D. McGinnis			JUNE 7 1995									5:15 A.M.		
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country) Chicago, Ill		
577-30-4733		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		67 YRS.		MONTHS		DAYS		4/17/28				
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING						9c. COUNTY OF DEATH MONTGOMERY		
RESIDENCE OF DECEASED														
10a. STATE Md.	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 1117 Snider Lane						10f. ZIP CODE 20904						10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1948-1952			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: NEGROID			14. RACE — American Indian, Black, White, etc. Specify:					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 Yrs			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher (Music)			16b. KIND OF BUSINESS/INDUSTRY EDUCATION								
17. FATHER'S NAME (First, Middle, Last) John McGinnis						18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Thompson								
19a. INFORMANT'S NAME (Type/Print) Yasmin K. McGinnis						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10 a,b,c,d,e, & f								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington			DATE 6/12/95		20c. LOCATION — City or Town, State Adelphia, Md.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juan Smith						22. NAME AND ADDRESS OF FACILITY John T. Rhines Co., Inc. 3030 12th St NE, DC 20017								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) →														
a. Spontaneous Bacteric Peritonitis DUE TO (OR AS A CONSEQUENCE OF): Massive ascites														
b. Massive ascites DUE TO (OR AS A CONSEQUENCE OF): Portal Hypertension														
c. Portal Hypertension DUE TO (OR AS A CONSEQUENCE OF): Alcoholic liver cirrhosis														
d. Alcoholic liver cirrhosis														
Approximate Interval Between Onset and Death 2 days														
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST														
yrs 9 years														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hepatorenephropathy														
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER Tung-pi Lee, M.D.						29c. LICENSE NUMBER D26707			29d. DATE SIGNED (Month, Day, Year) ► 6-7-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tung-pi Lee, M.D. 700 Buckingham Dr. Silver Spring 20901														
31. DATE FILED (Month, Day, Year) JUN 09 1995			32. REGISTRAR'S SIGNATURE John Anderson Hardell											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

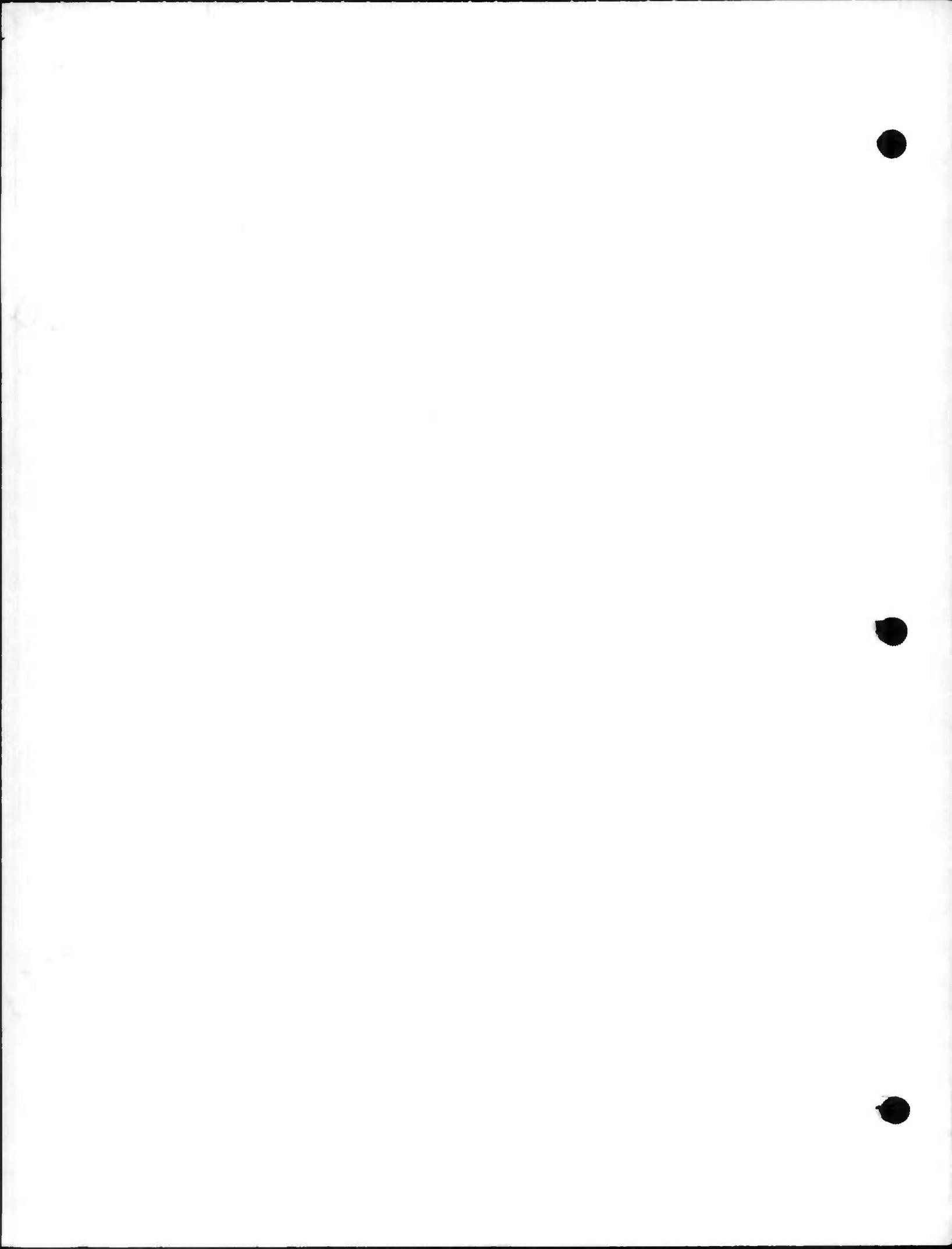
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
Darryl Lawrence Muse										June 6, 1995	445pm M		
4. SOCIAL SECURITY NUMBER			5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
577-74-4150			X <input type="checkbox"/> M <input checked="" type="checkbox"/> F	40 YRS.	MONTHS	DAYS	HOURS	MIN.	July 28, 1954		Rhode Island		
8a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH			
5717 Temple Hills Rd										Temple Hills Maryland			
RESIDENCE OF DECEDENT										9c. COUNTY OF DEATH			
10e. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
Maryland	Prince George			Temple Hills									
10e. STREET AND NUMBER										10f. ZIP CODE			
5717 Temple Hills										20748			
10g. CITIZEN OF WHAT COUNTRY?										United States			
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: Black			
1 <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	10-25-73			10-24-79									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)										16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			
Elementary/Secondary (0-12)			College (1-4 or 5+)			Claims Adjuster						16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Mintry R. Muse										Joan Wigginton Muse			
19e. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Joan Muse										5717 Temple Hills Rd Temple Hills Maryland 20748			
20e. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)										20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Vet Cheltonham 6-9-95 DATE Clinton Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i>										22. NAME AND ADDRESS OF FACILITY Alexander S. Pope Funeral Homes 5538 Marlboro Pike Forestville Maryland			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disseminated Mycobacterium Avium DUE TO (OR AS A CONSEQUENCE OF): <i>AIDS</i>										18 months			
b. DUE TO (OR AS A CONSEQUENCE OF): <i></i>										18 months			
c. DUE TO (OR AS A CONSEQUENCE OF): <i></i>													
d. DUE TO (OR AS A CONSEQUENCE OF): <i></i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, wasting										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Cameron MD</i>					29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year) <i>► 6/8/95</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MIRIAM L. CAMERON MD Kaiser Permanente 1011 N Capitol St NE</i>													
31. DATE FILED (Month, Day, Year) <i>JUN 6 1995</i>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)			BRAZZELL MACON								2. DATE OF DEATH MONTH DAY YEAR				
4. SOCIAL SECURITY NUMBER			5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		3. TIME OF DEATH				
577-32-0778			1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		74 YRS.		MONTHS DAYS		HOURS MIN.		6:12 AM				
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH								9c. COUNTY OF DEATH				
SOUTHERN MARYLAND Hospital			Clinton								PRINCE GEORGES				
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?			
MD		Prince Georges		Suitland								<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?					
2432 Green Valley Drive		20746								USA					
11. MARITAL STATUS			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES					13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:					14. RACE — American Indian, Black, White, etc.		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY				
Elementary/Secondary (0-12)			Printer								U.S. GOVT. Bureau of Engraving				
12th															
17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAME (First, Middle, Maiden Surname)												
Richard Allen			Della Johnson												
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
Nowall W. Macon			2432 Green Valley Dr. Suitland, MD 20746												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION/Name of cemetery, crematory or other place Ft. Lincoln Cemetery								DATE	20c. LOCATION — City or Town, State			
											6/6/95	Brentwood, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.P. Marshall</i>			22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc. 4308 Suitland Rd. Suitland, MD 20746												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pulmonary Carcinomatosis</i>															
Approximate Interval Between Onset and Death 1 year															
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											29c. LICENSE NUMBER <i>D26 352</i>			29d. DATE SIGNED (Month, Day, Year) <i>6/1/95</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>OL HAYE 9131 Liscataway Rd #540 Clinton MD 20735</i>															
31. DATE FILED (Month, Day, Year) <i>JUN 06 1995</i>			32. REGISTRAR'S SIGNATURE <i>John Andrew Randolph</i>												

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

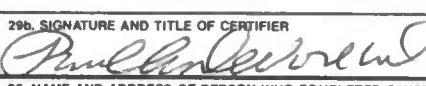
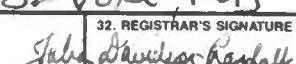
TO BE COMPLETED BY FUNERAL DIRECTOR

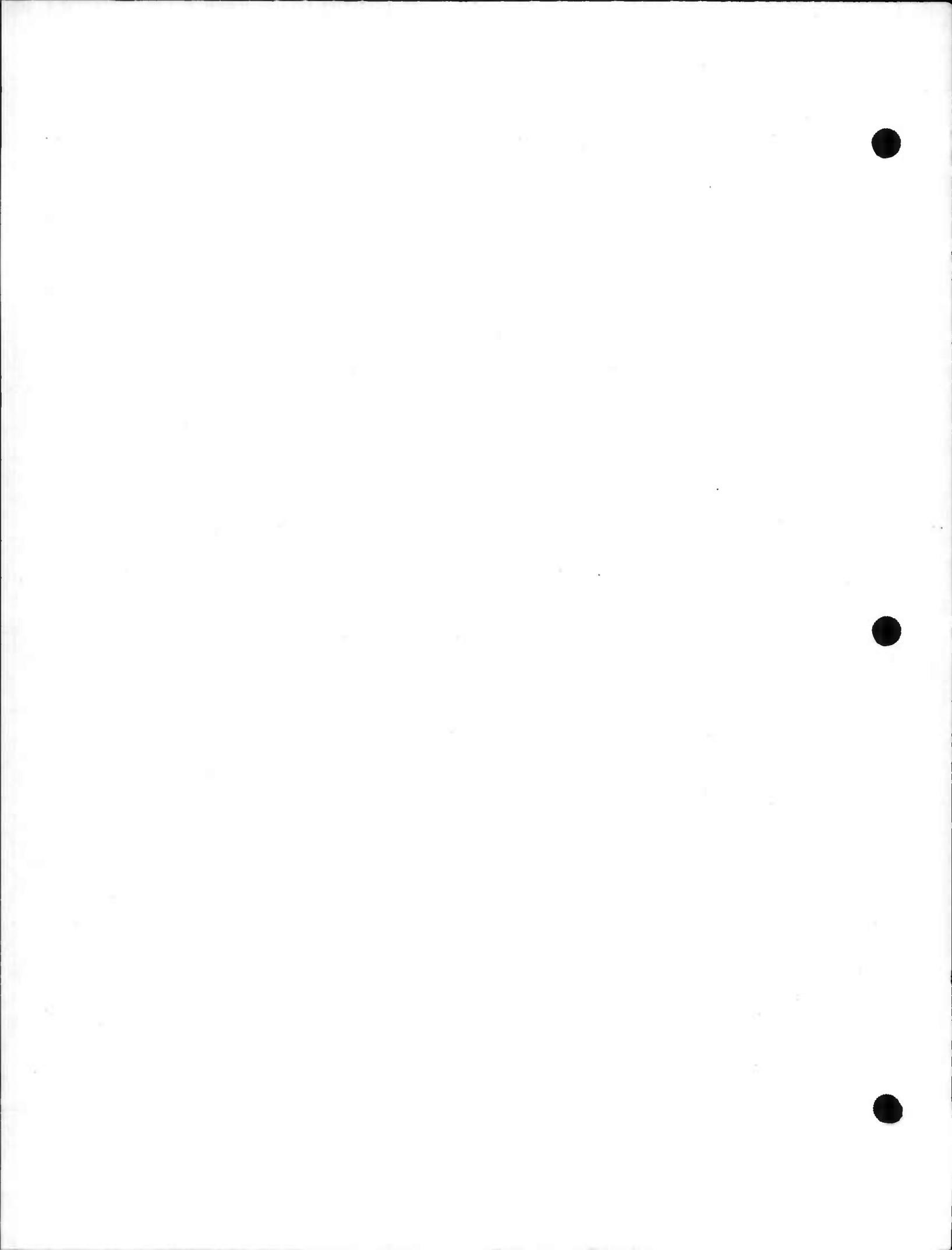
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19123

1. DECEASED'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH JUNE DAY 1 YEAR 1995				3. TIME OF DEATH 3:52 PM	
Anna Miller								
4. SOCIAL SECURITY NUMBER 118-30-2359		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		
				7. DATE OF BIRTH (Month, Day, Year) Nov 6 1911			8. BIRTHPLACE (State or Foreign Country) New York City, NY	
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Clinton				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 9400 Paul Drive			10f. ZIP CODE 20735				10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY Private			
17. FATHER'S NAME (First, Middle, Last) Unknown			18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Ziegler					
19a. INFORMANT'S NAME (Type/Print) Marie Garfinkel			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9400 Paul Drive, Clinton, Maryland 20735					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Catskill Rural Cemetery			DATE 6/5/95	20c. LOCATION — City or Town, State Catskill, N.Y.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY JORDAN FUNERAL SERVICE 4001 Benning Road, N. E., Washington, D.C.					
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death years								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Senile Dementia								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER DO 1852		29d. DATE SIGNED (Month, Day, Year) JUNE 1, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul A DeVore, MD 4203 (Queensbury Rd Hyattsville MD 20781)								
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 						



DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

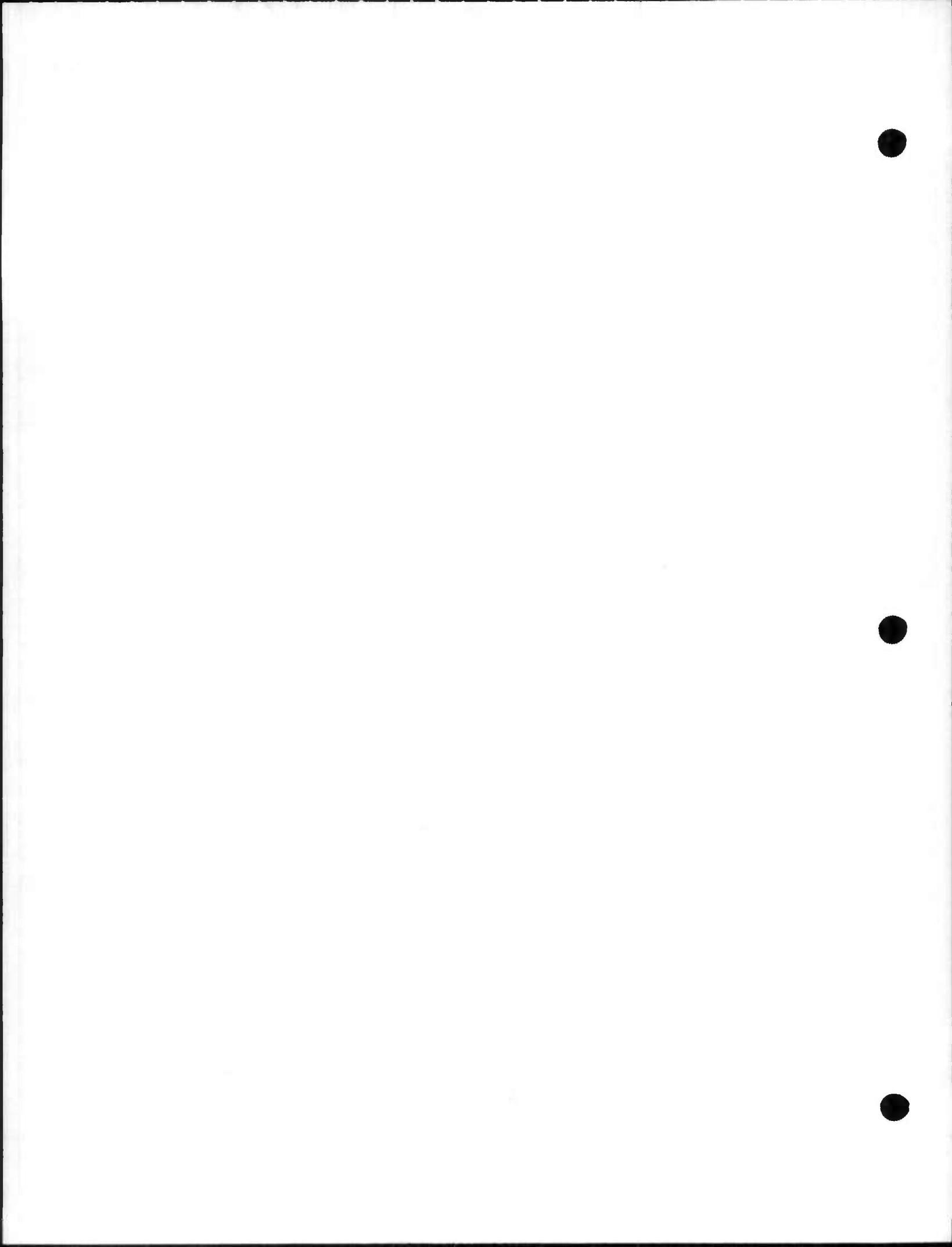
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH
LENA RITA MONICHELLI								JUNE 02 1995		7:04PM
4. SOCIAL SECURITY NUMBER 164-22-2998		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 22, 1917		8. BIRTHPLACE (State or Foreign Country) Illinois
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital Center								9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's
10e. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bladensburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 4200 51st Street								10f. ZIP CODE 20710	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY Private				
17. FATHER'S NAME (First, Middle, Last) (Unknown) Brocani								18. MOTHER'S NAME (First, Middle, Maiden Surname) Antonio Smachi		
19e. INFORMANT'S NAME (Type/Print) Barbara Goldbeck								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5804 Annapolis Road, #207, Bladensburg, MD 20710		
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery				DATE 6/07/95	20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles F. Bell Jr.</i>								22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 2 weeks		
b. <i>Septicemia</i> DUE TO (OR AS A CONSEQUENCE OF):								2 weeks		
c. <i>Hyper tension</i> DUE TO (OR AS A CONSEQUENCE OF):								Years		
d. <i>Congestive Heart Failure</i>								2 weeks		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Poochikian Vicki</i>		29c. LICENSE NUMBER <i>D 34722</i>		29d. DATE SIGNED (Month, Day, Year) <i>► 6-3-95</i>						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vicki Poochikian, M.D. 5632 Annapolis Road, Bladensburg, MD 20710										
31. DATE FILED (Month, Day, Year) <i>JUN 08 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Dawson-Randall</i>								



DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

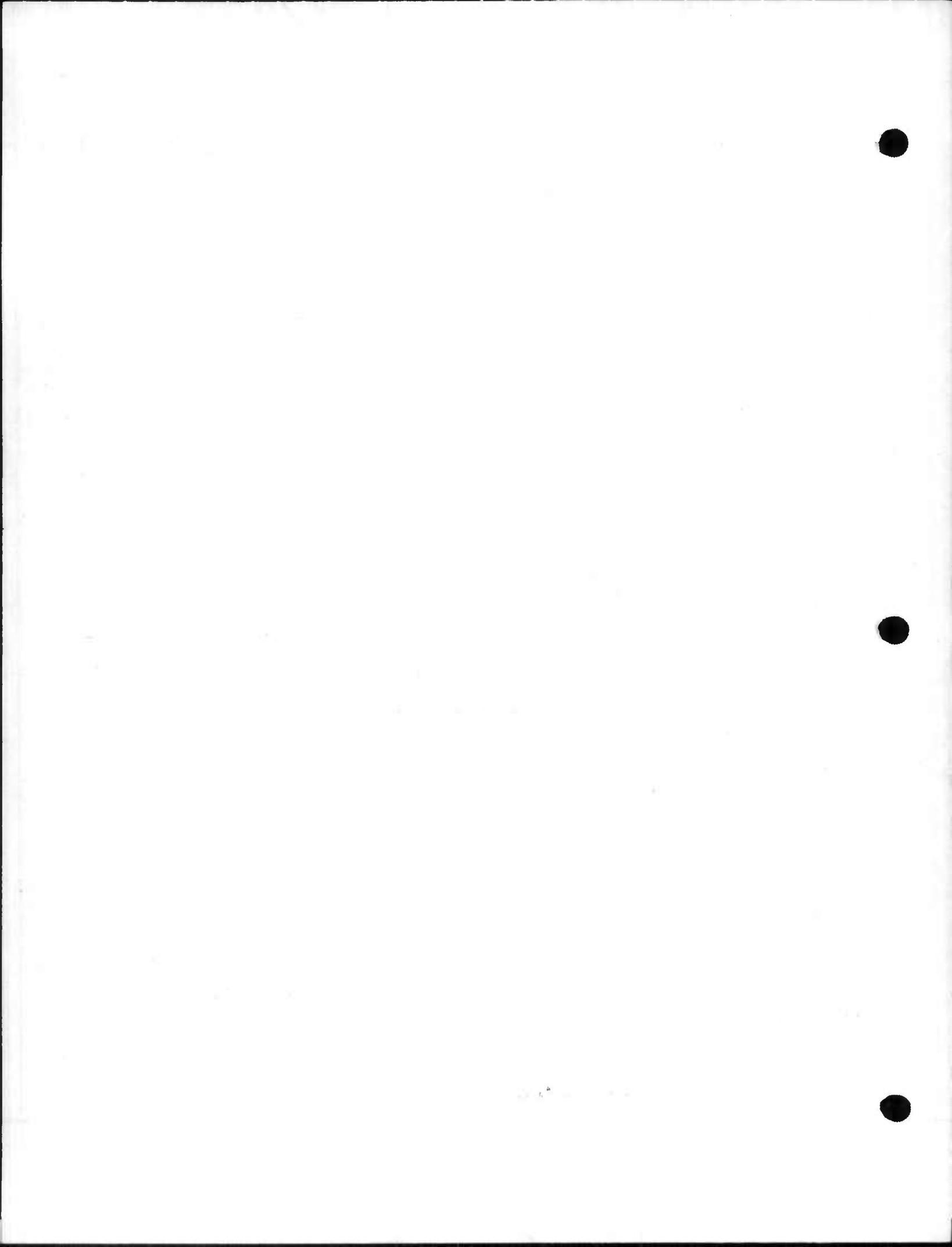
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 3, 1995										3. TIME OF DEATH 10:00 p m	
1. DECEDENT'S NAME (First, Middle, Last) ATOLLAH MERRIKH												7. DATE OF BIRTH (Month, Day, Year) Jan 1 1916	
4. SOCIAL SECURITY NUMBER 213 19 8732		5. SEX M		6. AGE (In yrs. last birthday) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Iran					
6a. FACILITY NAME (If not institution, give street and number) Doctor's Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Lanham, Maryland	
RESIDENCE OF DECEDENT												9c. COUNTY OF DEATH Prince George	
10a. STATE Maryland		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? YES					
10e. STREET AND NUMBER 13317 Yarland Lane						10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? Iranian					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDEDT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 14 years		13. WAS DECEDENT OF HISPAHIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Iranian		14. RACE — American Indian, Black, White, etc. Specify: Iranian							
15. DECEDEDT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 14 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Director		16b. KIND OF BUSINESS/INDUSTRY Postal Service Iranian Government									
17. FATHER'S NAME (First, Middle, Last) Mahmood Merrikh		18. MOTHER'S NAME (First, Middle, Maiden Surname) Belgis (unknown)											
19a. INFORMANT'S NAME (Type/Print) Behvar Merrikh		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13317 Yarland Lane Bowie Maryland											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Tehran, Iran		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6/10		20c. LOCATION — City or Town, State Washington, D.C. 20200									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Alay S. Farah		22. NAME AND ADDRESS OF FACILITY POPE FUNERAL HOMES 2617 Pennsylvania Ave Washington, D.C. 20200											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Sepsis Multiple drug resistant staph aureus DUE TO (OR AS A CONSEQUENCE OF):												2-3 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Disseminated intravascular coagulation DUE TO (OR AS A CONSEQUENCE OF): c. End stage bladder cancer DUE TO (OR AS A CONSEQUENCE OF): d.												24 hrs 1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Rohinton Farahi		29c. LICENSE NUMBER D43446		29d. DATE SIGNED (Month, Day, Year) 6/5/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROINTAN FARAH - FAR 4000 Mitchellville road B216 Bowie MD 20716													
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE Jahn Anderson Harrell											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

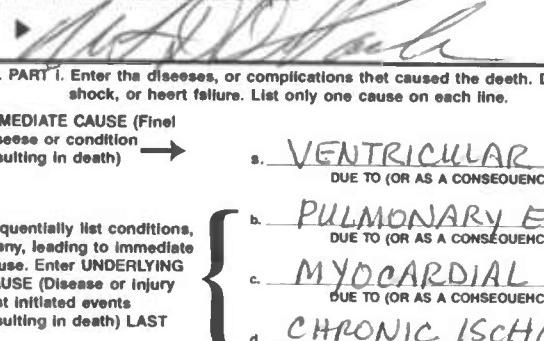
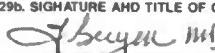
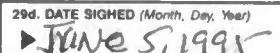
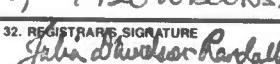
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

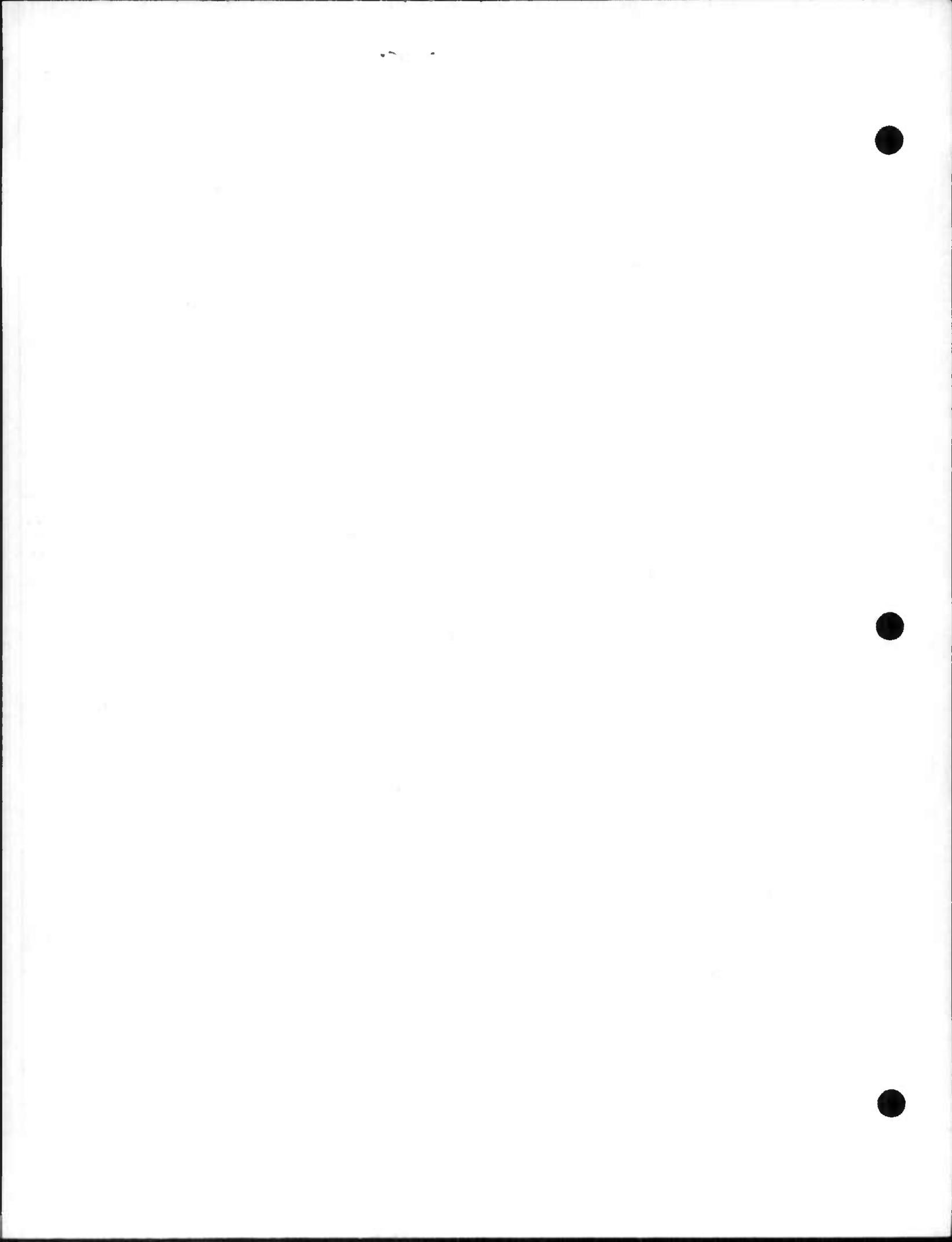
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											MUTINSKY	
VICTORIA		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2. DATE OF DEATH		
131-10-6705		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		85 YRS.		MONTHS		DAYS HOURS MIN.		MONTH DAY YEAR		
9a. FACILITY NAME (If not institution, give street and number)											Sept 9, 1909	
Southern Maryland Hospital Center											9b. CITY, TOWN OR LOCATION OF DEATH	
Clinton											9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT											PRINCE GEORGE'S	
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?	
Maryland	Prince George's		Clinton								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER											10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
5300 Riga Street											20735	United States
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				14. RACE — American Indian, Black, White, etc. Specify: White		
<input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced												
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12)		Clerk				Retail Sales						
17. FATHER'S NAME (First, Middle, Last)											18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Anthony Maduro											Teresa Troppa	
19a. INFORMANT'S NAME (Type/Print)											19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Frances Stewart											4804 Brinkley Road, Camp Springs, Md 20748	
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State						
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Resurrection Cemetery		June 8, 1995				Clinton, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE											22. NAME AND ADDRESS OF FACILITY	
											Lee Funeral Home, Inc 6633 Old Alexander Ferry Road, Clinton, Md 20735	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											minutes	
a. VENTRICULAR FIBRILLATION DUE TO (OR AS A CONSEQUENCE OF):												
b. PULMONARY EDEMA DUE TO (OR AS A CONSEQUENCE OF):											days	
c. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):											week	
d. CHRONIC ISCHEMIC HEART DISEASE												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?
Motor vehicle collision, contusions, (May 23, 1995)											<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											24c. DATE SIGNED (Month, Day, Year)	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)										
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED				
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		May 23, 1995		21:00 PM		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		CAR HIT WHILE STOPPED				
29e. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										
<input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
<input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		STUART + WOOD YARD RD, CLINTON										
29b. SIGNATURE AND TITLE OF CERTIFIER											29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
											D25925	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											31. DATE FILED (Month, Day, Year)	
J. BERGER MD #205, 7720 WISCONSIN Ave, Bethesda, Md 20814											JUN 13 1995	
32. REGISTRAR'S SIGNATURE												

95 19126



Items 23 Part II, 27 7-25-95 Film G725 W.H. Per OCME

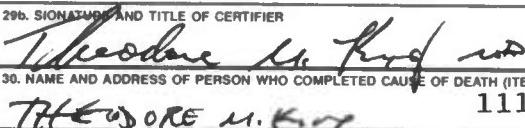
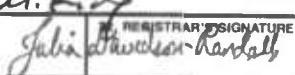
FOR 28a-f.

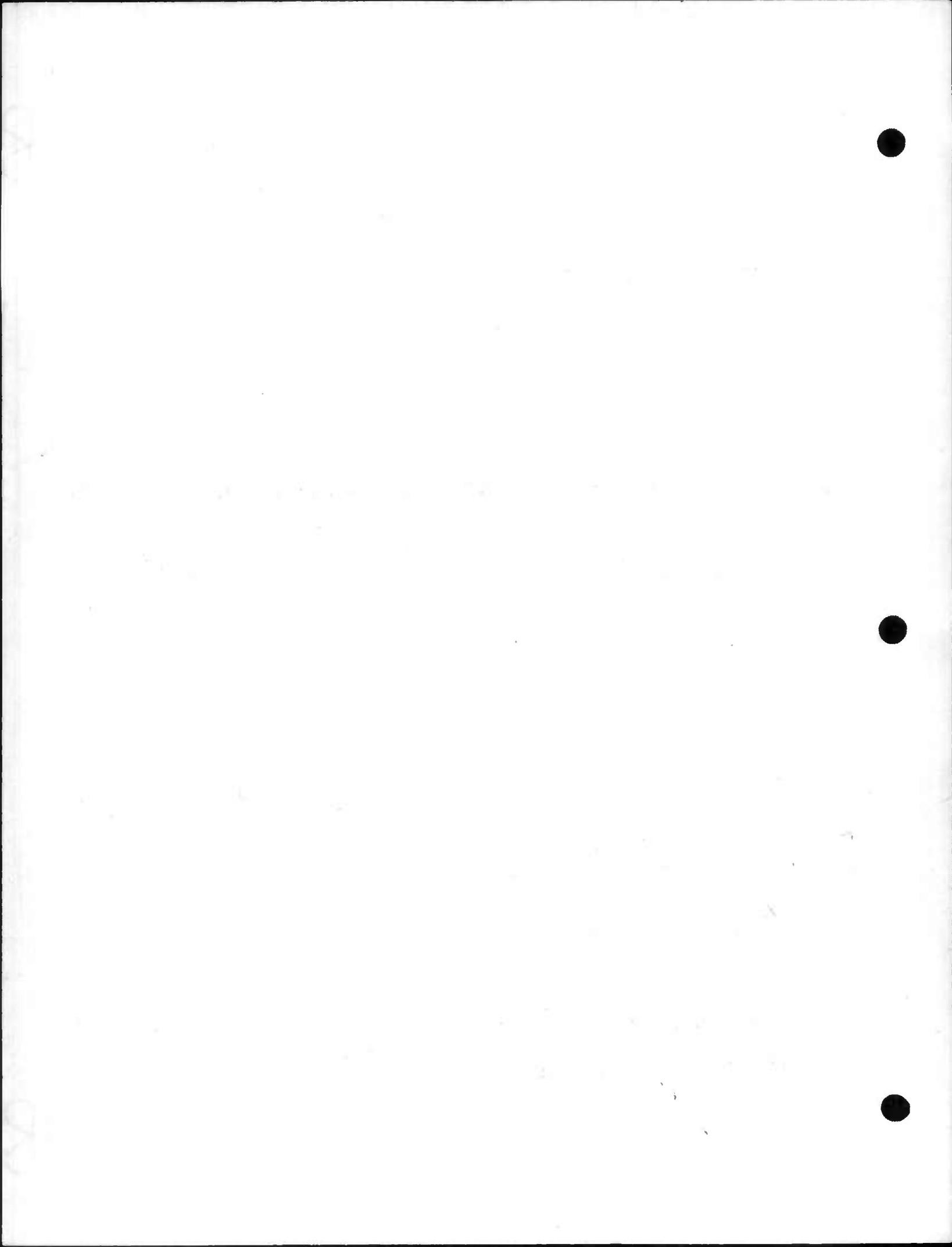
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19127

TO BE COMPLETED BY FUNERAL DIRECTOR		1. DECEDENT'S NAME (First, Middle, Last) VIOLA E. MEIXELL						2. DATE OF DEATH JUNE 4, 1995		3. TIME OF DEATH 1030 A.M.	
		4. SOCIAL SECURITY NUMBER 194-10-9002		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 10, 1907		8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) 104 CONCORD APARTMENTS		9b. CITY, TOWN OR LOCATION OF DEATH PERRYVILLE						9c. COUNTY OF DEATH CECIL			
10a. STATE Maryland		10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION Perryville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 104 Concord Apartments		10f. ZIP CODE 21903						10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES -----			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Six Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk			16b. KIND OF BUSINESS/INDUSTRY Perryville Newsstand Perryville, Maryland						
17. FATHER'S NAME (First, Middle, Last) Roy A. Stull		18. MOTHER'S NAME (First, Middle, Maiden Surname) Surriah Mackes									
19a. INFORMANT'S NAME (Type/Print) Elizabeth L. Alexander		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 232 Mountain Road, Perryville, Maryland 21903									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bethlehem Memorial Park			DATE 6/8/95	20c. LOCATION — City or Town, State Bethlehem, Pennsylvania					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		HEAD INJURIES COMPLICATING HYPERTENSIVE ARTERIOSCLEROTIC DUE TO (OR AS A CONSEQUENCE OF): CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home XX Residence 8 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 6-4-95		28b. TIME OF INJURY 9:50 AM	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED SUBJECT FELL		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) 104 CONCORD APTS. PERRYVILLE, MARYLAND			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.						29d. DATE SIGNED (Month, Day, Year) JUNE 5, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. Key		31. DATE FILED (Month, Day, Year) JUN 09 1995						32. REGISTRAR'S SIGNATURE 			



95 19128

1 -
FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

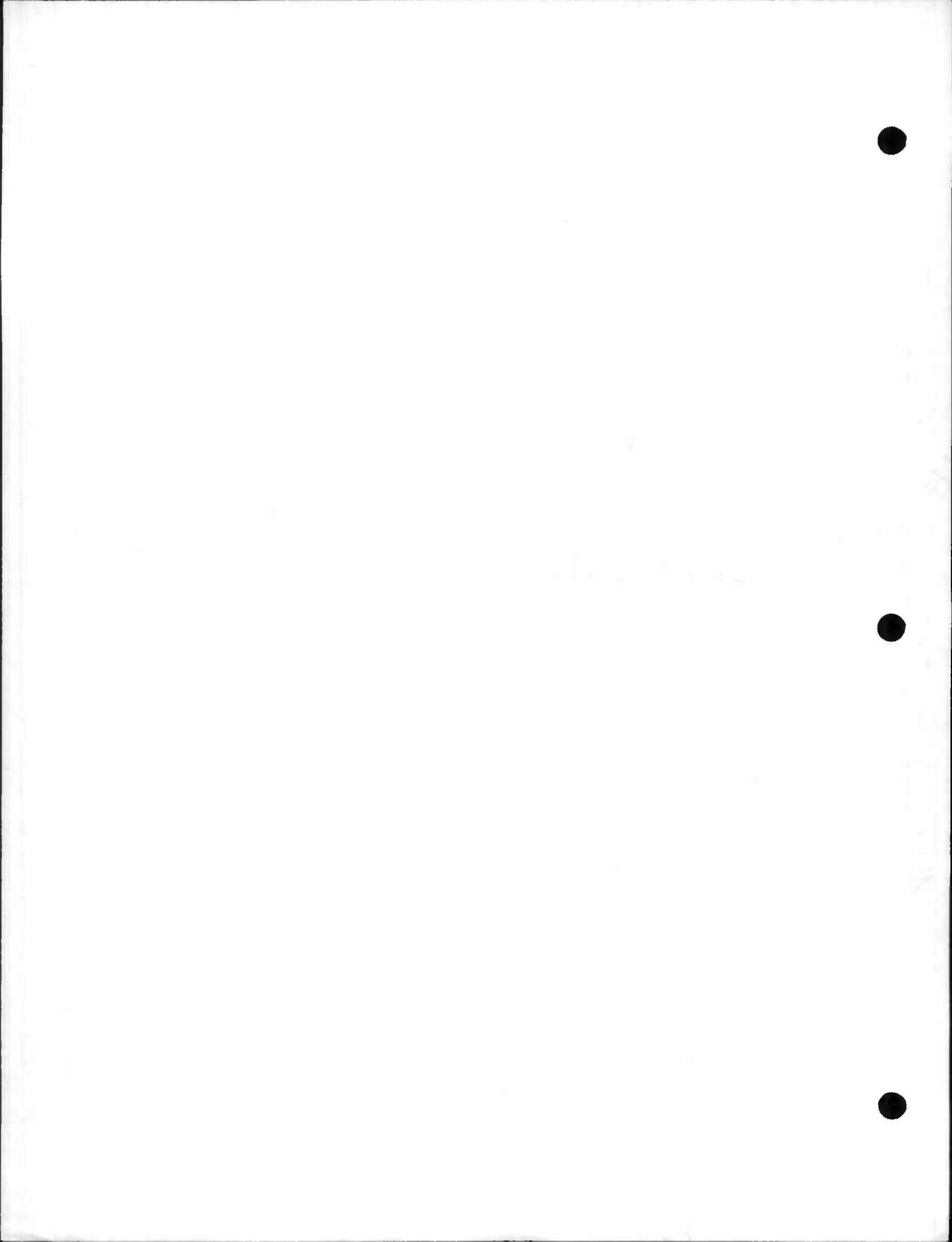
TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
		REG. NO.									
<p>1. DECEASED'S NAME (First, Middle, Last) Ella Kathryn Meekins</p> <p>2. DATE OF DEATH 6-1-95 <small>YEAR</small> JUNE 1 95 <small>M</small></p> <p>3. TIME OF DEATH 1540</p> <p>4. SOCIAL SECURITY NUMBER 220-50-4792</p> <p>5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</p> <p>6. AGE (In yrs. last birthday) 83 YRS.</p> <p>7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.</p> <p>8. FACILITY NAME (If not institution, give street and number) Union Hospital of Cecil County</p> <p>9. CITY, TOWN OR LOCATION OF DEATH Elkton</p> <p>10. COUNTY OF DEATH Cecil</p> <p>11. RESIDENCE OF DECEASED</p> <p>10b. STATE Maryland</p> <p>10b. COUNTY Cecil</p> <p>10c. CITY, TOWN OR LOCATION Elkton</p> <p>10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>10e. STREET AND NUMBER 344 Hollingsworth Manor</p> <p>10f. ZIP CODE 21921</p> <p>10g. CITIZEN OF WHAT COUNTRY? U.S.A.</p> <p>11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</p> <p>12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES</p> <p>13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White</p> <p>14. RACE — American Indian, Black, White, etc. Specify:</p> <p>15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College</p> <p>16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker</p> <p>16b. KIND OF BUSINESS/INDUSTRY</p> <p>17. FATHER'S NAME (First, Middle, Last) Harry Herbert Clayton</p> <p>18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Anna Yost</p> <p>19a. INFORMANT'S NAME (Type/Print) Dudley J. Meekins</p> <p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 121 Hearthstone Drive - Elkton, MD 21921</p> <p>20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)</p> <p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Immaculate Conception Cem. 1995</p> <p>20c. LOCATION — City or Town, State Cherry Hill, Maryland</p> <p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dorothy L. Hicks</p> <p>22. NAME AND ADDRESS OF FACILITY Hicks Home for Funerals, P.A. 103 West Stockton Street Elkton, MD 21921-5521</p> <p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration pneumonia</p> <p>Approximate Interval Between Onset and Death</p> <p>a. Aspiration pneumonia DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Laryngeal cancer. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST</p> <p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ASCAD Emphysema Chemotherapy induced anemia.</p> <p>24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p> <p>27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide</p> <p>28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</p> <p>28d. DESCRIBE HOW INJURY OCCURRED</p> <p>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. SIGNATURE AND TITLE OF CERTIFIER John R. Mulvey, M.D.</p> <p>29c. LICENSE NUMBER D45155</p> <p>29d. DATE SIGNED (Month, Day, Year) ► 6/1/95</p> <p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John R. Mulvey, M.D. 118 North St Suite 2A Elkton, Md</p> <p>31. DATE FILED (Month, Day, Year) JUN 07 1995</p> <p>32. REGISTRAR'S SIGNATURE Julia Dawson-Randall</p>											

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



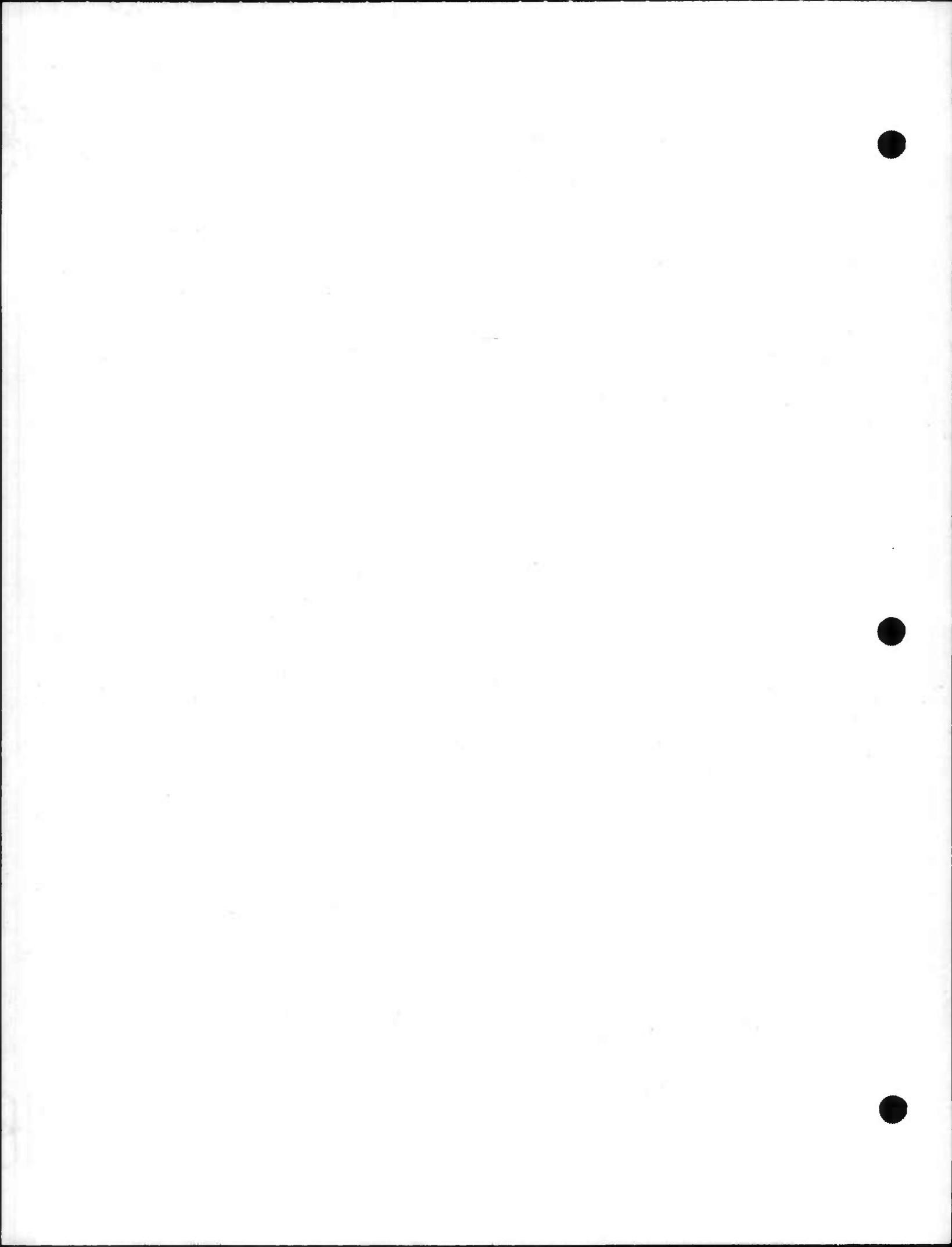
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		MARGARET MANN						2. DATE OF DEATH MONTH JUNE DAY 8 YEAR 1995		3. TIME OF DEATH 16:00	
4. SOCIAL SECURITY NUMBER 577-18-0904		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		7. DATE OF BIRTH (Month, Day, Year) Sept 28 1919		8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda						9c. COUNTY OF DEATH Montgomery			
10a. STATE Md.		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Poolesville						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14525 Montevideo Road		10f. ZIP CODE 20837						10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2 yrs				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Price B. Blackwell		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Gardner									
19a. INFORMANT'S NAME (Type/Print) Margaret Mann Drachsler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1730 K. St., N.W., Ste 304 Wash. D.C. 20006									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Smithsburg				DATE		20c. LOCATION — City or Town, State Smithsburg, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Margaret C. Mann</i>		22. NAME AND ADDRESS OF FACILITY Hilton Funeral Home Barnesville, Md. 20838									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. SUBDURAL HEMATOMA DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 13 DAYS											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) May 26 95		28b. TIME OF INJURY P M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED FELL DOWN STAIRS			
28e. PLACE OF INJURY — At home, farm, street, factory, office HOME		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) #10									
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Francis C. Mayle</i>		29c. LICENSE NUMBER D07099				29d. DATE SIGNED (Month, Day, Year) JUNE 8 95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MAYLE 10215 FERNWOOD RD BETHESDA MD 20817											
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>Jeanne L. Marshall</i>									

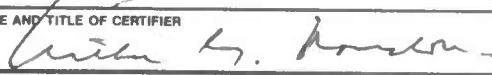


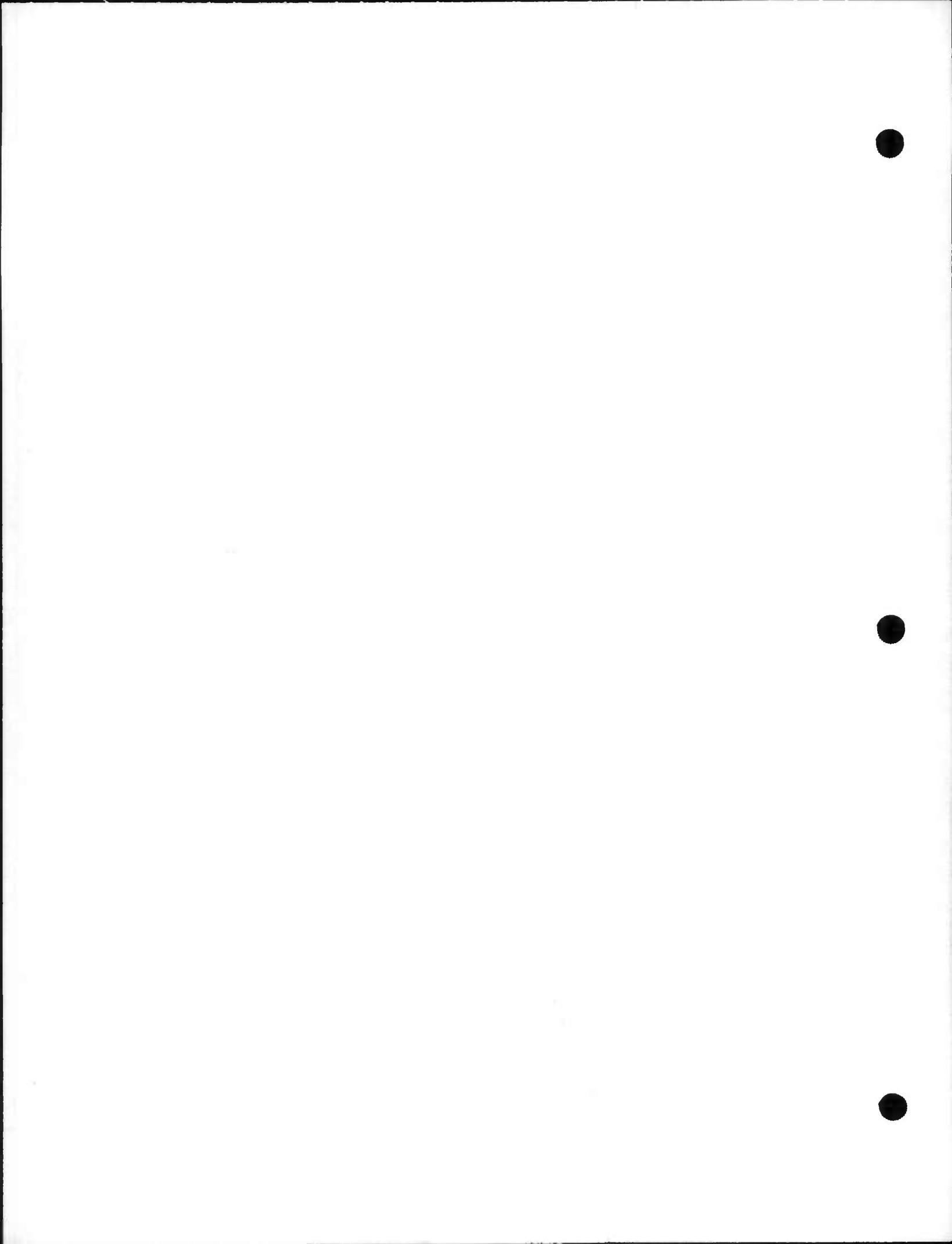
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020
TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) EDWARD JOSEPH MADDEN												2. DATE OF DEATH MONTH DAY YEAR June 5, 1995	3. TIME OF DEATH 3:30 A. M		
4. SOCIAL SECURITY NUMBER 407-28-1301		5. SEX 1 XX M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 22, 1901		6. BIRTHPLACE (State or Foreign Country) New York					
9a. FACILITY NAME (If not institution, give street and number) Frederick Health Care Center												9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick	
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STATE Florida	10b. COUNTY Brevard	10c. CITY, TOWN OR LOCATION Eau Gallie													
10e. STREET AND NUMBER 1105 Hyde Park Lane												10f. ZIP CODE 32935	10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)				16b. KIND OF BUSINESS/INDUSTRY 2 Engineer									
17. FATHER'S NAME (First, Middle, Last) Robert Washington Madden												18. MOTHER'S NAME (First, Middle, Maiden Surname) Johanna Agnes Corcoran			
19a. INFORMANT'S NAME (Type/Print) Robert P. Madden		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12730 Knoll Road Mt. Airy, Maryland 21771													
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory				DATE 6/6/95	20c. LOCATION — City or Town, State Hagerstown, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike Frederick, MD 21702													
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death > 5 yrs			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. End Stage Prostate cancer															
DUE TO (OR AS A CONSEQUENCE OF): a. Cancer Prostatic															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. Cancer Prostatic															
DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. d. Dying of sepsis															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 7 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND	28d. DESCRIBE HOW INJURY OCCURRED										
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D-18191				29d. DATE SIGNED (Month, Day, Year) ► 6-5-95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Arthur Manalo, M.D. 187 Thomas Johnson Drive Frederick, MD 21701															
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

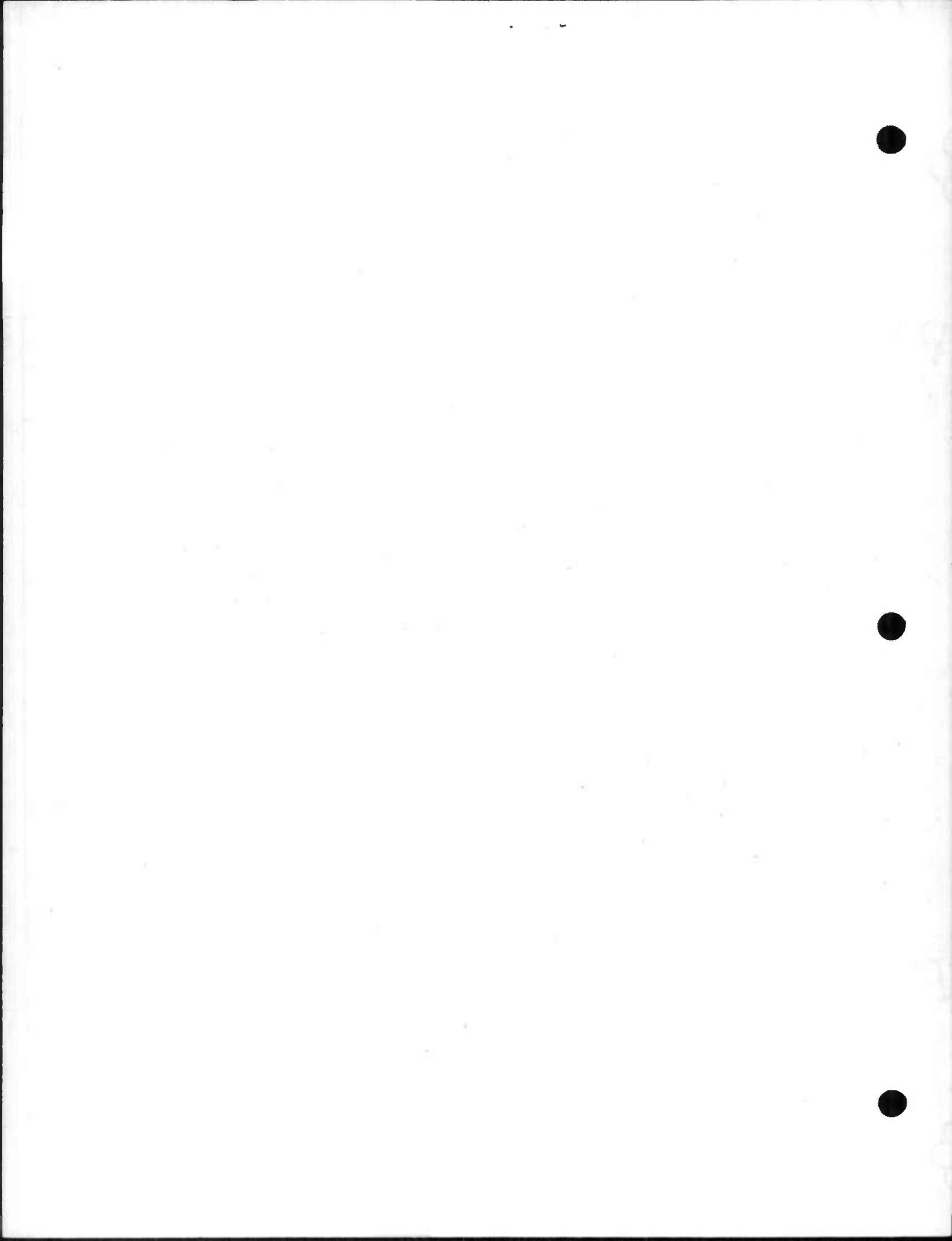
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR		1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH	3. TIME OF DEATH		
JOHN FRANCIS McGRAIN										MONTH	DAY	YEAR	1995	7:38P	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
212-22-9269		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		67 YRS.		MONTHS		DAYS		Dec 3, 1927		Maryland			
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH										9c. COUNTY OF DEATH			
Washington County Hospital		Hagerstown										Washington			
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION										10d. INSIDE CITY LIMITS?	
West VA.		Berkley		Hedgesville										<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER		10f. ZIP CODE										10g. CITIZEN OF WHAT COUNTRY?			
5013 Woods Resort		25427										United States			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)										14. RACE — American Indian, Black, White, etc. Specify:	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES 1946-1948		<input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)										16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12)		College (1-4 or 8+)		Manager/Vice President										Banking Loyola Federal Savings	
4															
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)													
Joseph W. McGrain		Ann Loretta Schott													
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
Mary L. McGrain		5013 Woods Resort Hedgesville, WV													
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State									
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) entombment		Crest Lawn		6-17		Marriottsville, MD									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY													
►Shem A. Collins		Harry H. Witzke Funeral Home Inc 4112 Old Columbia Pike Ellicott City 21043													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												20 DAY			
e. BRAINSTEM INFARCTION DUE TO (OR AS A CONSEQUENCE OF):															
b. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): X															
c. DUE TO (OR AS A CONSEQUENCE OF): X															
d. DUE TO (OR AS A CONSEQUENCE OF): X															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
X												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)													
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED							
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		N/A		N/A M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		N/A							
29a. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office N/A										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A			
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Maryan g nay		29c. LICENSE NUMBER D28365										29d. DATE SIGNED (Month, Day, Year) ► 6/13/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 368 MILL ST HAGERSTOWN MD 21740															
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE Julia Shucker Randall													

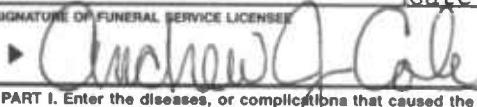


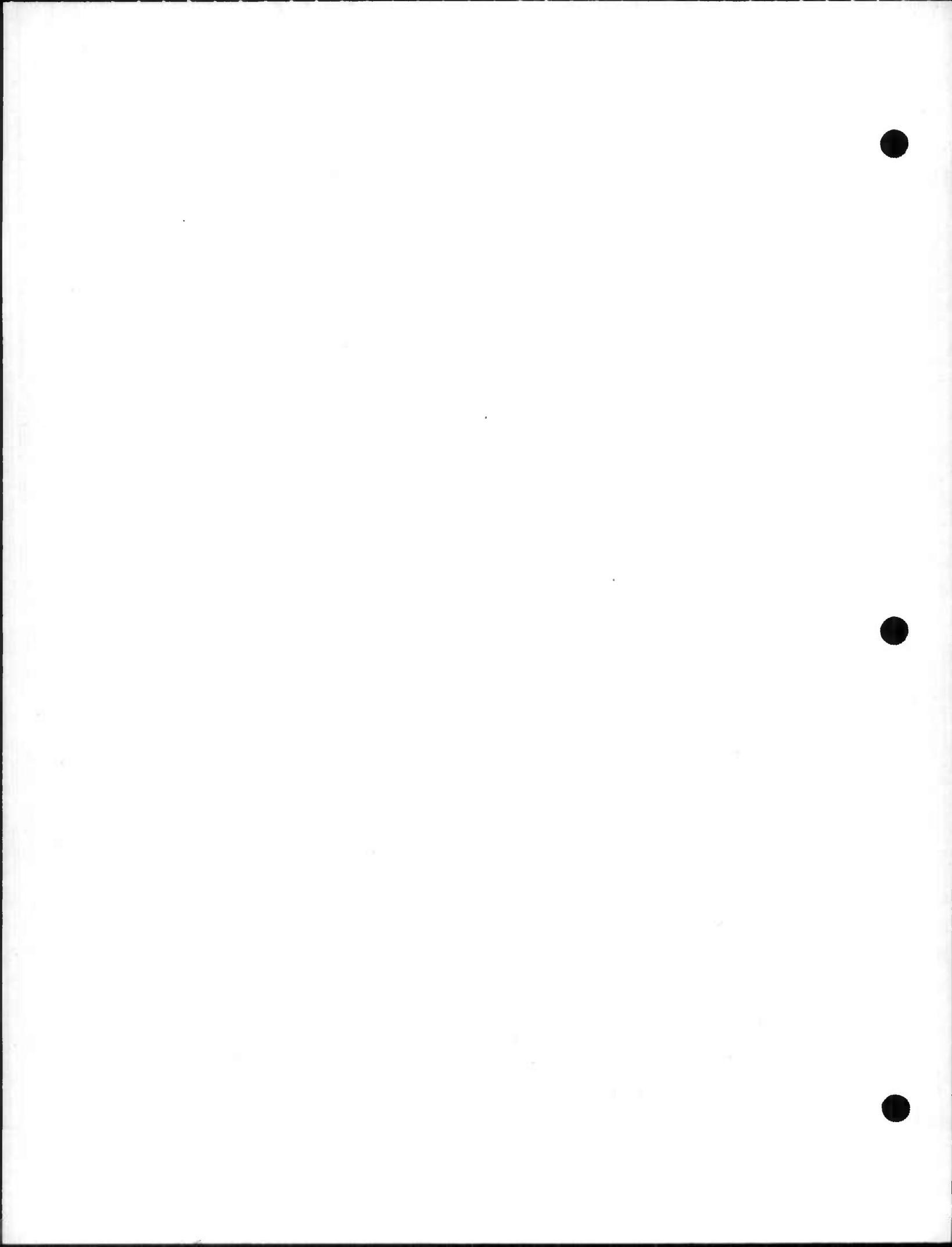
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Louise Arial Nourie												2. DATE OF DEATH MONTH DAY YEAR June 1 1995	3. TIME OF DEATH H = 55 AM		
4. SOCIAL SECURITY NUMBER 249-24-7993		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct. 20, 1918		8. BIRTHPLACE (State or Foreign Country) South Carolina			
9a. FACILITY NAME (If not institution, give street and number) 8604 Leonard Drive												9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring								10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 8604 Leonard Drive												10f. ZIP CODE 20910		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 1 Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home											
17. FATHER'S NAME (First, Middle, Last) Unknown												18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown			
19a. INFORMANT'S NAME (Type/Print) Richard F. Nourie												19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8604 Leonard Drive Silver Spring, Maryland 20910			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery		DATE 6/5/95		20c. LOCATION — City or Town, State Silver Spring, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 												22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate interval Between Onset and Death years			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. arteriosclerotic heart disease															
DUE TO (OR AS A CONSEQUENCE OF): a.															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b.															
DUE TO (OR AS A CONSEQUENCE OF): c.															
DUE TO (OR AS A CONSEQUENCE OF): d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 408546		29d. DATE SIGNED (Month, Day, Year) ► June 2 95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Nourie 8218 Wisconsin Ave															
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE 													



95 19133

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

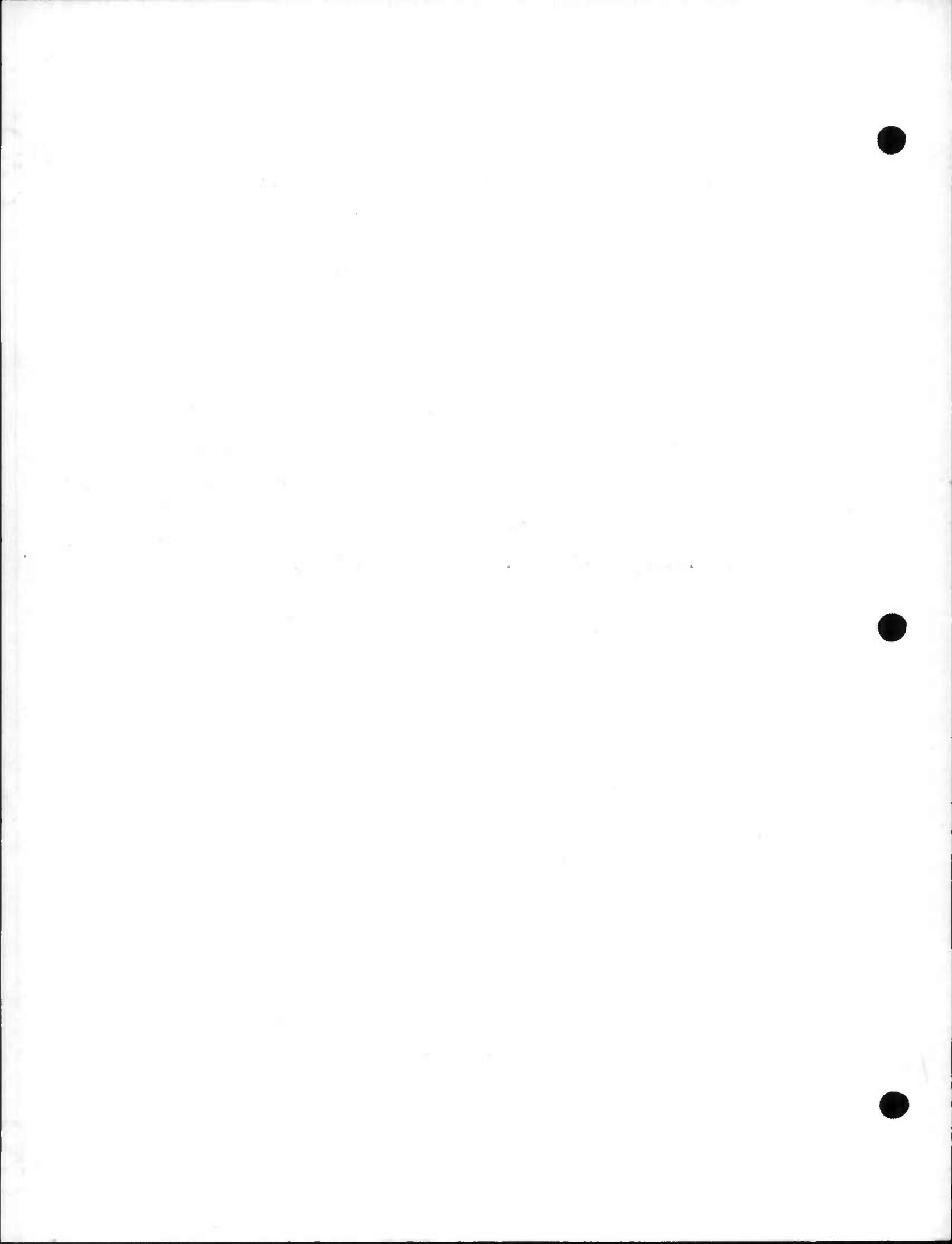
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		Nelle Sperow Nicewarner						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 0145 A.M.		
4. SOCIAL SECURITY NUMBER 216-40-5381		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 97 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 31, 1897		8. BIRTHPLACE (State or Foreign Country) West Virginia		
9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rockville						9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT												
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 215 Harrison Street		10f. ZIP CODE 20850						10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES -						13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) -		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) College (1-4 or 5+) 2 Homemaker						16b. KIND OF BUSINESS/INDUSTRY Own Home				
17. FATHER'S NAME (First, Middle, Last) Oscar L. Sperow		18. MOTHER'S NAME (First, Middle, Maiden Surname) Eliza Billmyer										
19a. INFORMANT'S NAME (Type/Print) Jennifer N. Gaegler		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4931 Baffin Bay Lane, Rockville, Maryland 20853										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rockville Cemetery June 6, 1995						20c. LOCATION — City or Town, State Rockville, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc., 300 W. Montgomery Ave Rockville, Maryland 20850-2805										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Urosepsis</u> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Days												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Alzheimer's Syndrome</u> <u>Atrial Fibrillation</u> <u>Hypertension</u>												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		26a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. LICENSE NUMBER 0-19042			29d. DATE SIGNED (Month, Day, Year) ► June 05, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BYRL D. JOHNSON M.D., 911 Russell Avenue, Gaithersburg, MD. 20879												
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE Julia Dawson-Randall										



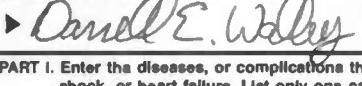
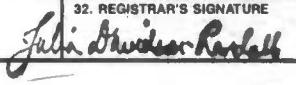
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

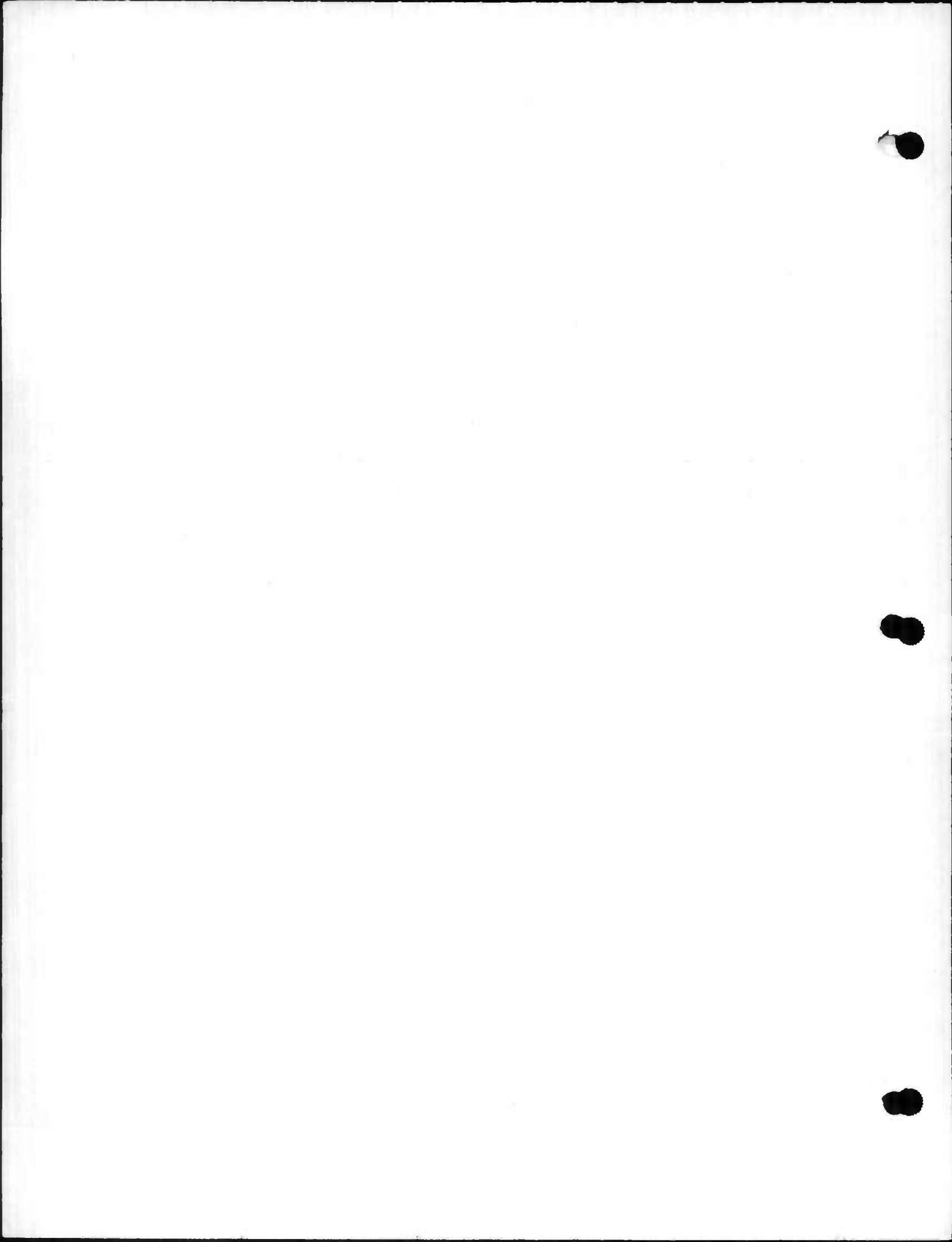
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 95 19134			
1. DECEDENT'S NAME (First, Middle, Last) Rae E. Nehls, Jr.												2. DATE OF DEATH MONTH May DAY 8 YEAR 1995	3. TIME OF DEATH 7:10 P M		
4. SOCIAL SECURITY NUMBER 354-12-2717		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year) 3-20-26	8. BIRTHPLACE (State or Foreign Country) Illinois		
9a. FACILITY NAME (If not institution, give street and number) National Institute of Health												9b. CITY, TOWN OR LOCATION OF DEATH Bethesda	9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT															
10a. STATE Virginia	10b. COUNTY Fairfax	10c. CITY, TOWN OR LOCATION Fairfax										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 9504 Harrowhill Lane												10f. ZIP CODE 22015	10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Caucasian					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4				16b. KIND OF BUSINESS/INDUSTRY Lt. Col.				17. FATHER'S NAME (First, Middle, Last) Rae E. Nehls, Sr.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Estelle Ray		
19a. INFORMANT'S NAME (Type/Print) Rae E. Nehls, III				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 45554 Whitcomb Square Sterling, Virginia 20166											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery				20c. LOCATION — City or Town, State Arlington, VA							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Everly Funeral Home 10565 Main Street, Fairfax, VA 22030											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 8 days			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Adult Respiratory Distress Syndrome <small>DUE TO (OR AS A CONSEQUENCE OF):</small> b. Liver Abscess <small>DUE TO (OR AS A CONSEQUENCE OF):</small> c. <small>DUE TO (OR AS A CONSEQUENCE OF):</small> d. 															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER BT2558659	29d. DATE SIGNED (Month, Day, Year) ► 6/6/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SHAHRIYARA TAVAKOLI MD NIH BETHESDA, MARYLAND															
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

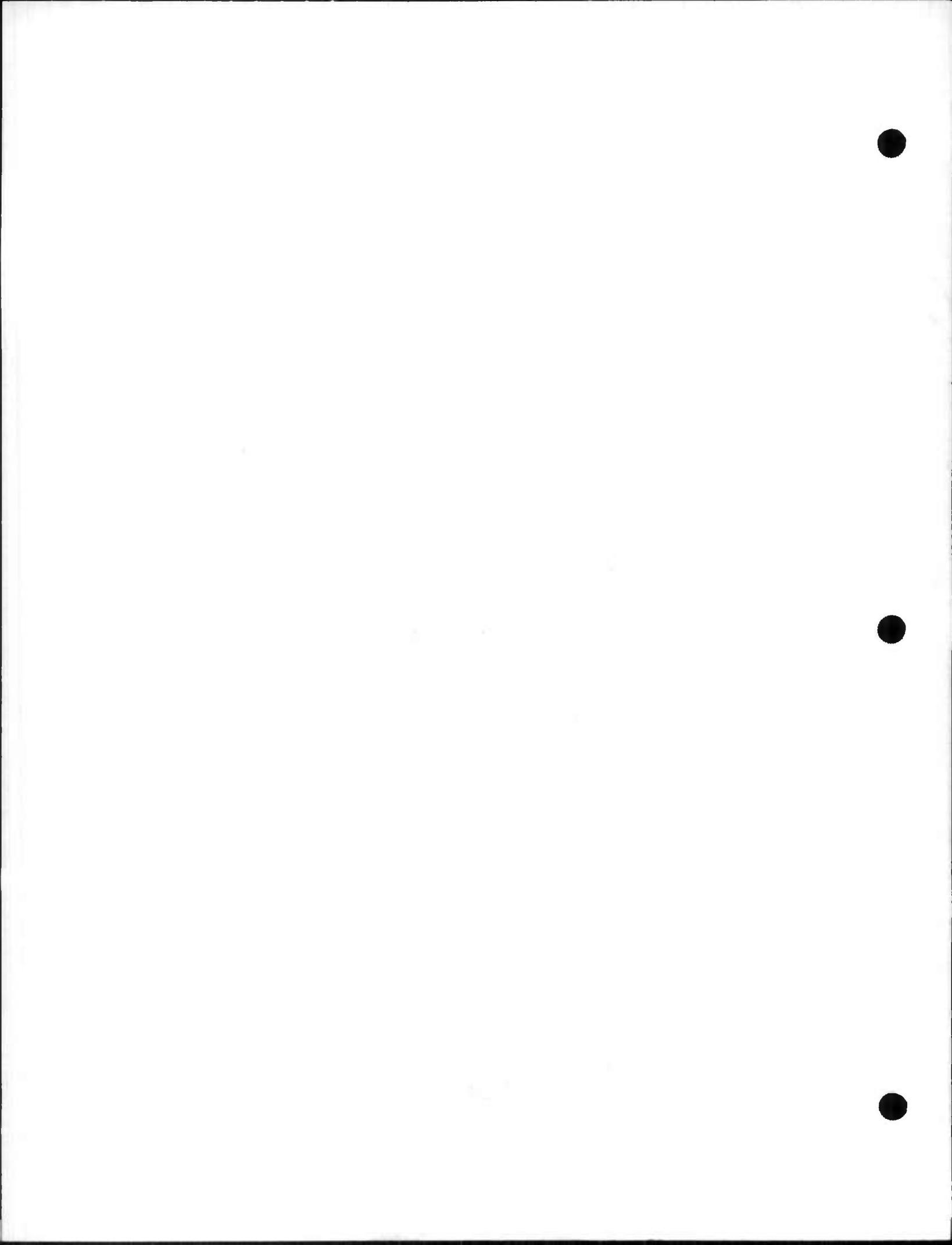
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19135

1. DECEASED'S NAME (First, Middle, Last)		Louis Joseph Niebel				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH P.M.
4. SOCIAL SECURITY NUMBER 212-16-9983		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov. 8, 1920	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston				9c. COUNTY OF DEATH Harford	
10a. STATE Maryland	10b. COUNTY Harford	10c. CITY, TOWN OR LOCATION Bel Air				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 513 East Courtland Place		10f. ZIP CODE 21014				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Supply Branch of Logistics Directorate		16b. KIND OF BUSINESS/INDUSTRY U.S. Government			
17. FATHER'S NAME (First, Middle, Last) Norman (u/k) Niebel		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae (nnn) MacDonald					
19a. INFORMANT'S NAME (Type/Print) Ranae Robinson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1119 G. Vanguard Way, Bel Air, Md. 21015					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, cemetery or other place) Bel Air Memorial Gardens		DATE 6/14/95	20c. LOCATION — City or Town, State Bel Air, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSE 		22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 Days					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		25. DUE TO (OR AS A CONSEQUENCE OF): E. Coli Septicemia Peritonitis Ruptured Diverticular Abscess					
{		26. DUE TO (OR AS A CONSEQUENCE OF): Cardiomyopathy with Low Output Failure					
27. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>		28a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24c. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29b. SIGNATURE AND TITLE OF CERTIFIER Marco A. Zamora MD		29c. LICENSE NUMBER D40819				29d. DATE SIGNED (Month, Day, Year) June 11, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARCO A. ZAMORA, MD 200 Milton Avenue, Fallston, Maryland 21047							
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE John Jackson Randall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

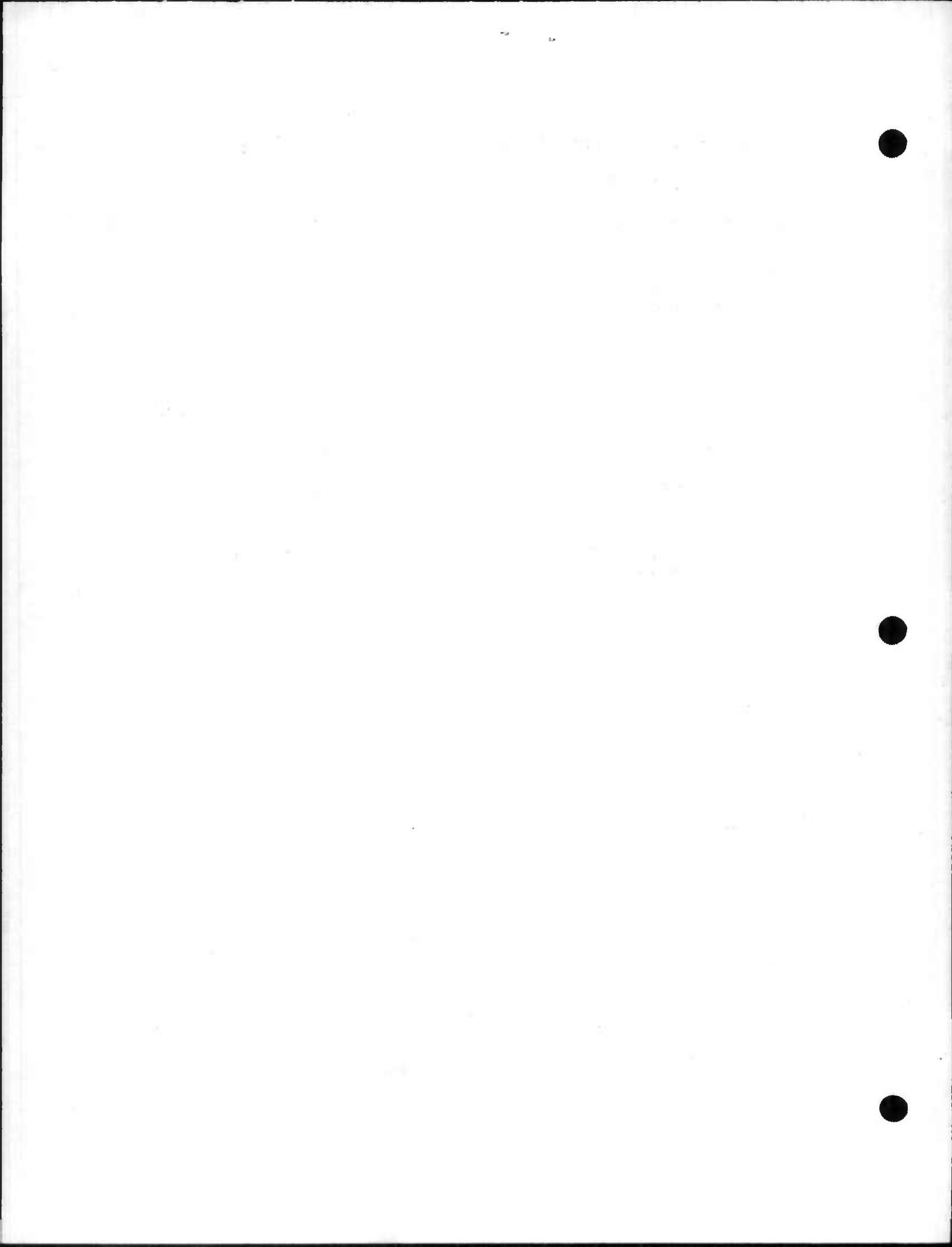
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		MAYNARD NELSON						2. DATE OF DEATH MONTH JUNE DAY 9 YEAR 1995		3. TIME OF DEATH 11:09 A.M.	
4. SOCIAL SECURITY NUMBER 216 - 16 - 0370		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie						7. DATE OF BIRTH (Month, Day, Year) Sept 04, 1925		8. BIRTHPLACE (State or Foreign Country) Maryland	
RESIDENCE OF DECEDENT 10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Gambrills						9c. COUNTY OF DEATH ANNE ARUNDEL	
10e. STREET AND NUMBER 1029 Springhill Way								10f. ZIP CODE 21054		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> ND IF YES, GIVE WAR OR DATES 1947 - 1952		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White						14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Clerk		16b. KIND OF BUSINESS/INDUSTRY United States Post Office							
17. FATHER'S NAME (First, Middle, Last) John A. Nelson		18. MOTHER'S NAME (First, Middle, Maiden Surname) Katie Whitehead									
19a. INFORMANT'S NAME (Type/Print) Julia B. Nelson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1029 Springhill Way, Gambrills, Maryland 21054									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		DATE 6/12		20c. LOCATION — City or Town, State Brentwood, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) → s. <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Ishemic heart disease</i>										Approximate Interval Between Onset and Death 2 yrs	
b. <i>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</i> c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i> d. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 31122		29d. DATE SIGNED (Month, Day, Year) ► 6/9/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Kevin Doyle 203 Hospital Drive Suite 206 Glen Burnie MD 21061											
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE Julia A. Kuehnle-Pattall									



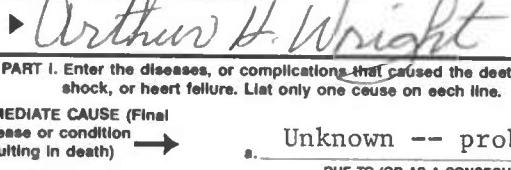
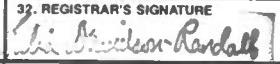
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

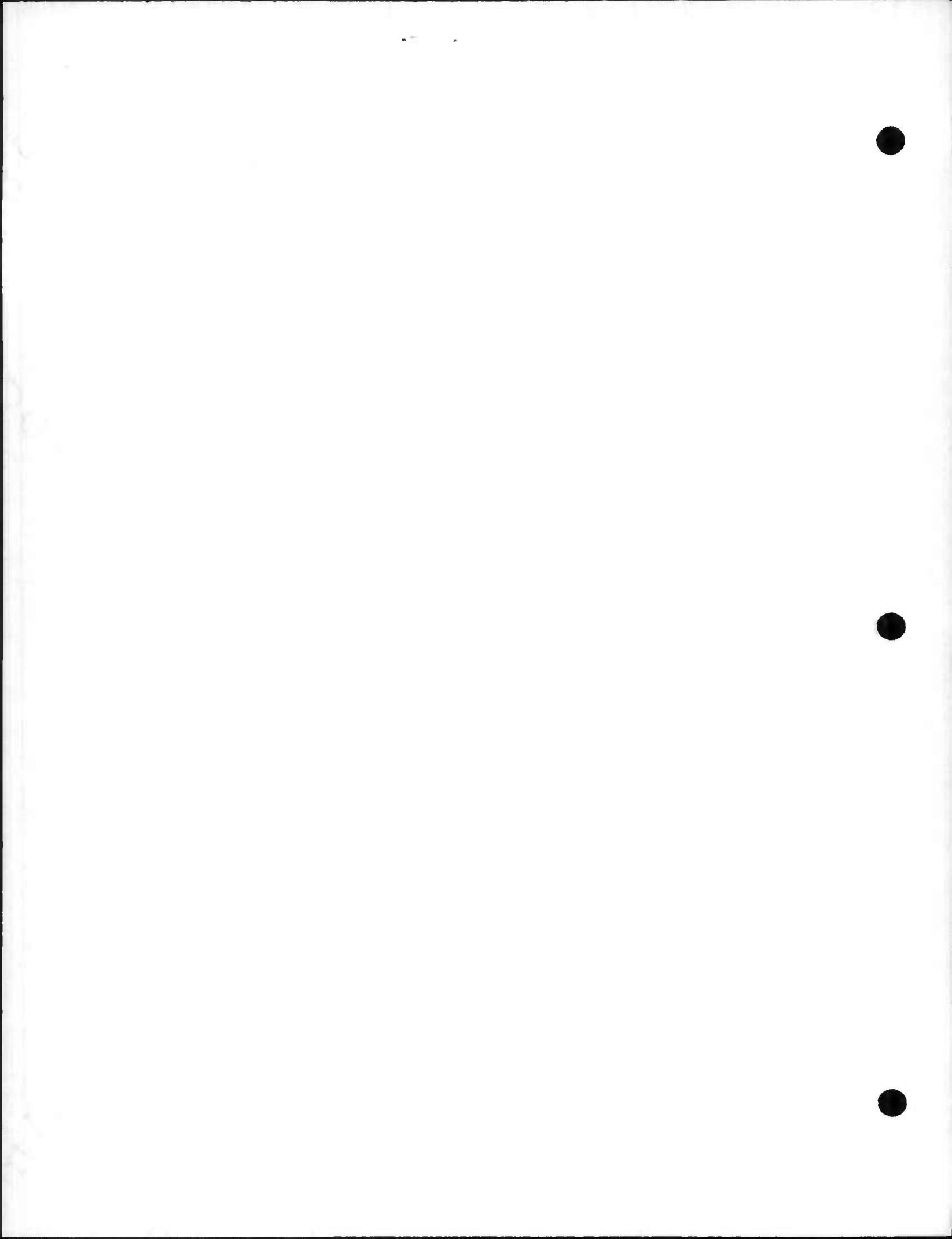
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)												
Alice Elizabeth Niner												
4. SOCIAL SECURITY NUMBER 232-80-2109		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2. DATE OF DEATH MONTH June	DAY 21	YEAR 1995	3. TIME OF DEATH 8:55 p.m.			
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Oakland	9c. COUNTY OF DEATH Garrett	
10a. STATE W.Va.										10b. COUNTY Preston	10c. CITY, TOWN OR LOCATION Terra Alta	
10e. STREET AND NUMBER 309 Second St.										10f. ZIP CODE 26764	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Domestic							
17. FATHER'S NAME (First, Middle, Last) Mavy R. Mellott										18. MOTHER'S NAME (First, Middle, Maiden Surname) Vella Friend		
19e. INFORMANT'S NAME (Type/Print) Garnet Elsey										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 309 Second Street Terra Alta, WV 26764		
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrett Co. Mem. Gardens 1995			DATE			20c. LOCATION — City or Town, State Oakland, Me.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Arthur H. Wright Funeral Home, Inc. 105 Highland Ave. Terra Alta, WV 26764										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death		
a. Unknown -- probable ventricular dysrhythmia DUE TO (OR AS A CONSEQUENCE OF):										1 min.		
b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):										6 days		
c. Pulmonary Embolus DUE TO (OR AS A CONSEQUENCE OF):										11 Days		
d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month, Day, Year) 6/21/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Karl E. Schwalm 311 N. 4th St., Oakland, MD 21550		32. REGISTRAR'S SIGNATURE 								31. DATE FILED (Month, Day, Year) JUN 22 1995		



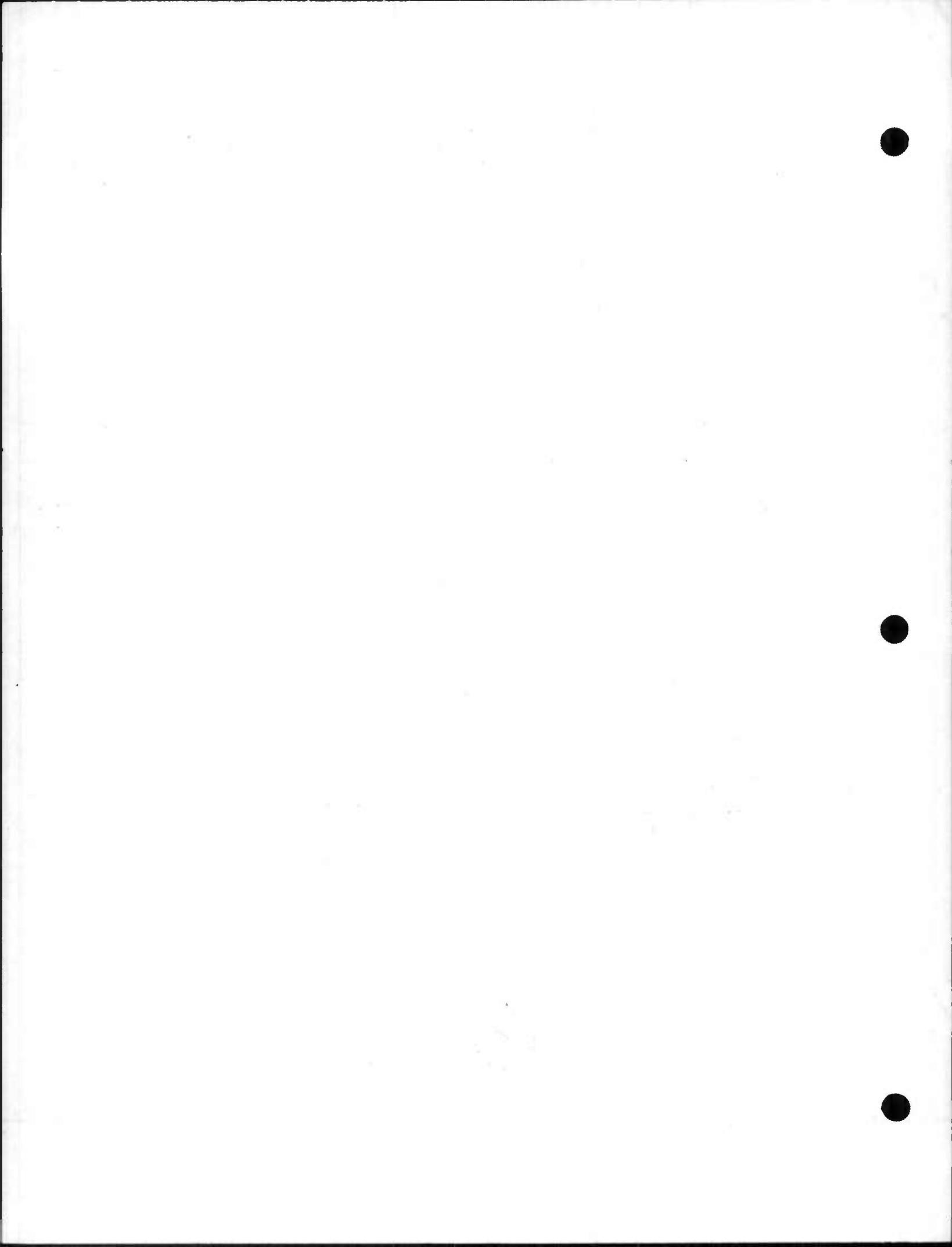
Amended # 109, 6/9/95, JW, Montgomery Co.

95 19138

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
		REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last)		Melvina Olliverrie				2. DATE OF DEATH		YEAR		3. TIME OF DEATH			
						MONTH JUNE		1995		12:30P M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
578-96-9212		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		73 YRS.		MONTHS		DAYS		HOURS MIN.			
6a. FACILITY NAME (If not institution, give street and number)		Doctor's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH		Lanham				8. BIRTHPLACE (State or Foreign Country)	
RESIDENCE OF DECEDENT												Trinidad	
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?							
Md.		Prince George		Ft. Washington		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
6910 Greenboro Lane						20744		Trinidad United States					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
18. DECEDENT'S EDUCATION (Specify only highest grade completed)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				18b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 12		College (1-4 or 8+) Housewife				NA							
17. FATHER'S NAME (First, Middle, Last)		16. MOTHER'S NAME (First, Middle, Maiden Surname)											
Shanleara Roberts		S. Thomas											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Lawrence Olliverrie		6910 Greenboro Lane, Ft. Washington, Md. 20744											
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Western Unknown Cemetery				6/13		dad Port of Spain, Trini-					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY											
<i>J. N. Horton</i>		R. N. Horton Co. Morticians, Inc. 600 Kennedy St., N. W., Wash., DC											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <i>Severe Perivascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):											
{		c. <i>Insulin Dependent diabetes mellitus</i> DUE TO (OR AS A CONSEQUENCE OF):											
		d. <i>Hyperkalemia</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
<i>Bilateral AKA - resulting in poor healing due to lack of blood supply to leg</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)				24a. WAS AN AUTOPSY PERFORMED?				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
29a. CERTIFIER (Check only one)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)					
<i>John B. Theobalds</i>						D 2350		► 6-8-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE											
JUN 09 1995		<i>John B. Theobalds</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

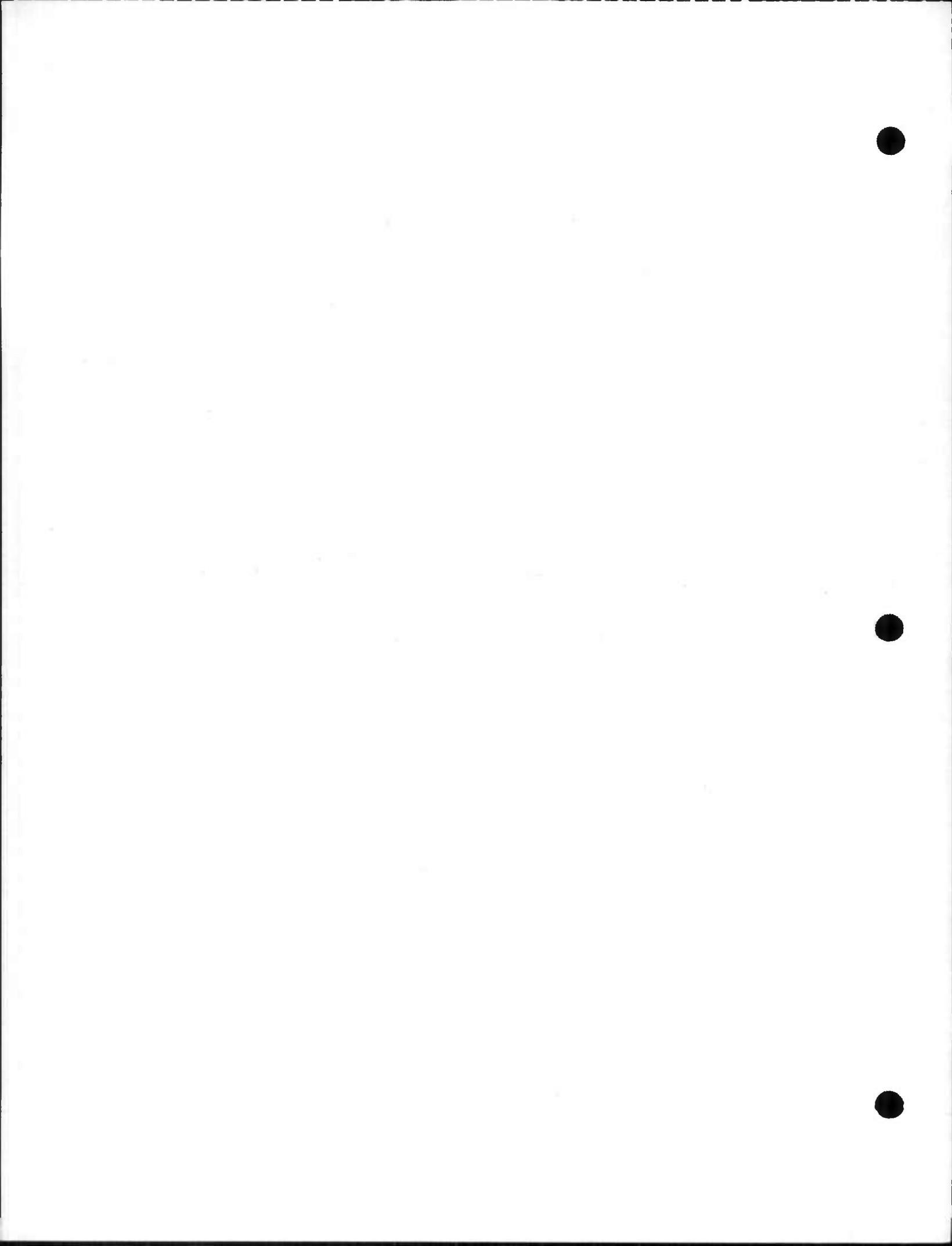
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Josephine Occhipinti								2. DATE OF DEATH MONTH DAY YEAR June 6, 1995		3. TIME OF DEATH 4:20 A. M.
4. SOCIAL SECURITY NUMBER 141-09-7936		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept 15, 1909		8. BIRTHPLACE (State or Foreign Country) New Jersey		
9a. FACILITY NAME (If not institution, give street and number) Mediplex of Montgomery Village								9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg		9c. COUNTY OF DEATH Montgomery
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 8 Deer Park Lane				10f. ZIP CODE 20877				10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Seamstress			16b. KIND OF BUSINESS/INDUSTRY Clothing Manufacturer					
17. FATHER'S NAME (First, Middle, Last) Andrea Laterra				18. MOTHER'S NAME (First, Middle, Maiden Surname) Salvatrice Ferrincieri						
19a. INFORMANT'S NAME (Type/Print) Frances Arietano				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 Deer Park Lane, Gaithersburg, Maryland 20877						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Madonna Mausoleum			DATE 6/6	20c. LOCATION — City or Town, State Fort Lee, New Jersey				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J. D. Johnson</i>		22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death days	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Urosepsis DUE TO (OR AS A CONSEQUENCE OF):										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ischemic Cardiomyopathy									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide							28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		29. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							28a. DATE OF INJURY (Month, Day, Year) M 28b. TIME OF INJURY 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Byrl D. Johnson MD</i>		29c. LICENSE NUMBER D19042							29d. DATE SIGNED (Month, Day, Year) ► June 6, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Byrl D. Johnson, M.D. 911 Russell Ave., Gaithersburg, Maryland 20879									31. DATE FILED (Month, Day, Year) JUN 08 1995	
									32. REGISTRAR'S SIGNATURE <i>Julin Shuler-Randall</i>	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

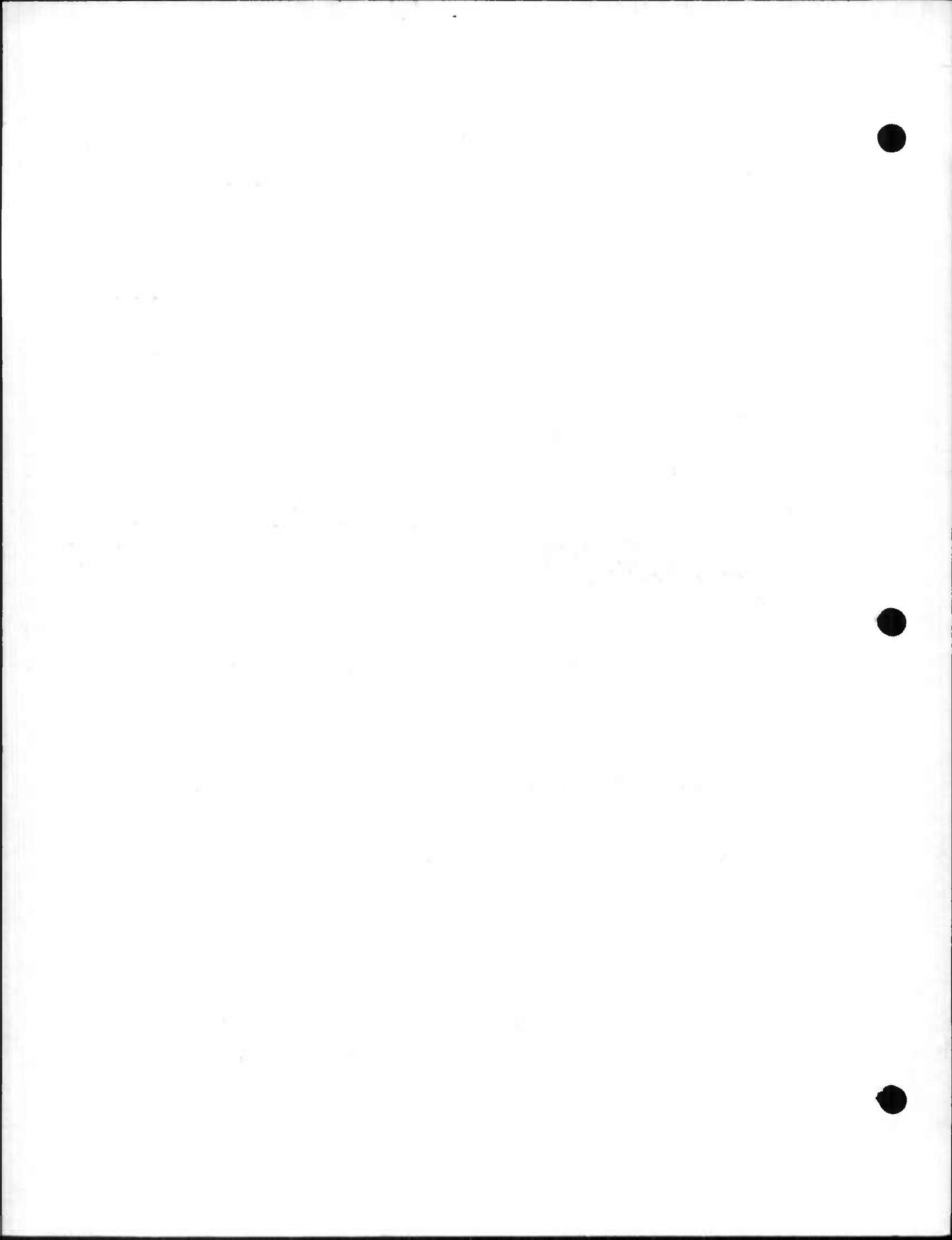
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Jerome A O'Leary											2. DATE OF DEATH MONTH June DAY 9 YEAR 1995	3. TIME OF DEATH 2:05 PM	
4. SOCIAL SECURITY NUMBER 153-12-4140		5. SEX XX M 2 F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Aug. 6, 1920	8. BIRTHPLACE (State or Foreign Country) New Jersey						
9a. FACILITY NAME (If not institution, give street and number) Manor Care Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH Largo			9c. COUNTY OF DEATH Prince George's							
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Clinton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 8409 Schultz Road				10f. ZIP CODE 20735			10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1945			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Caucasian			14. RACE — American Indian, Black, White, etc. Caucasian					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Conductor			16b. KIND OF BUSINESS/INDUSTRY Railroad								
17. FATHER'S NAME (First, Middle, Last) Jerome		18. MOTHER'S NAME (First, Middle, Maiden Surname) O'Leary Christine Coyne											
19a. INFORMANT'S NAME (Type/Print) Ginger O'Leary				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip, Code) 121 Coral Way East Apt 3 Indialantic Florida 32903									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland State Veterans Cem.			20c. LOCATION — City or Town, State Cheltenham, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735									
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → C. <i>Cardiomyopathy</i> D. <i>coronary artery Disease</i>										Approximate Interval Between Onset and Death Sys sys			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST C. <i>Anoxic Encephalopathy</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anoxic Encephalopathy</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED								
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D34274								29d. DATE SIGNED (Month, Day, Year) ► 6-12-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Tellawi MD										31. DATE FILED (Month, Day, Year) JUN 13 1995			32. REGISTRAR'S SIGNATURE Jane Shuler-Randall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

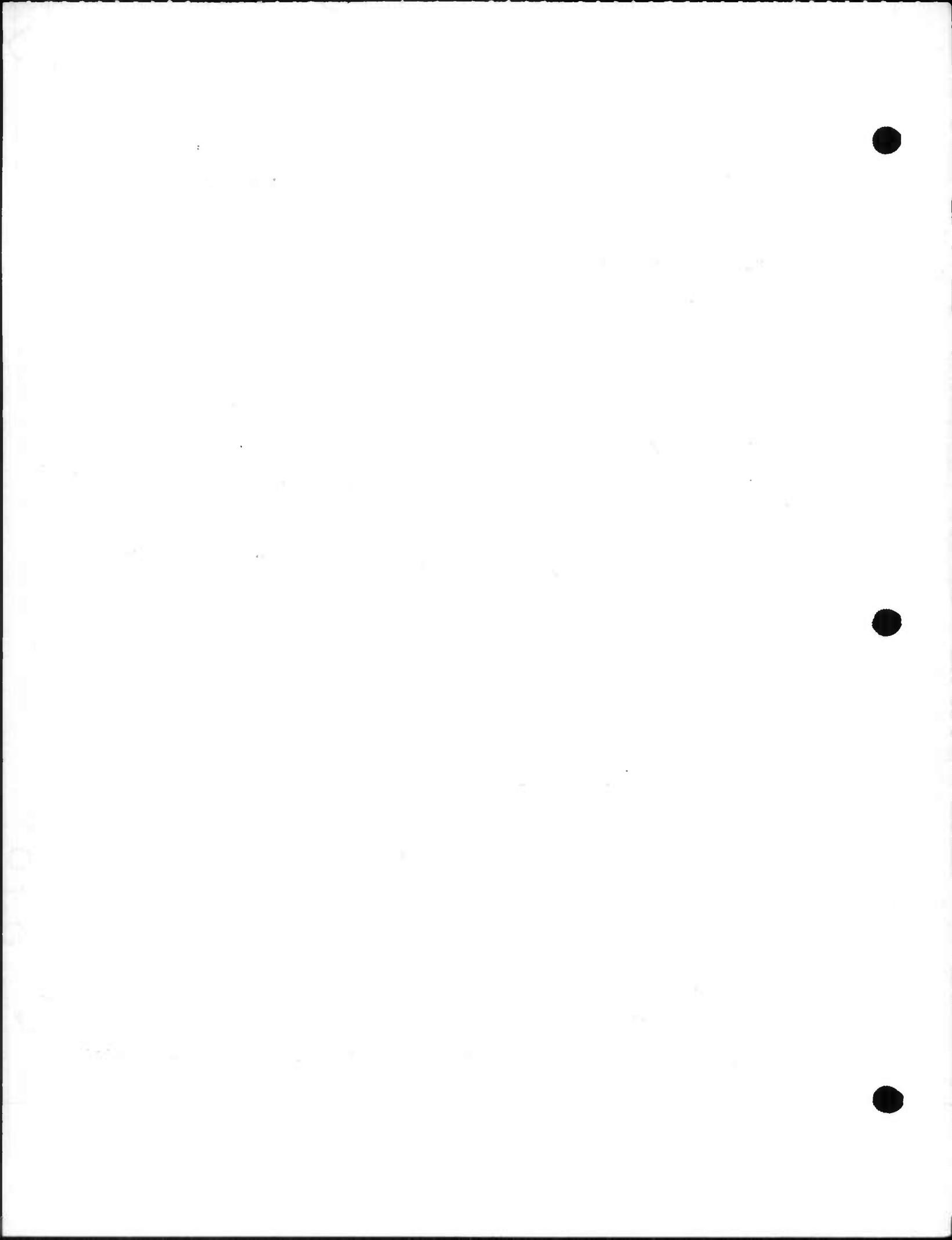
TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 1914

1. DECEDENT'S NAME (First, Middle, Last) Willard Lee Orem						2. DATE OF DEATH MONTH DAY YEAR June 6, 1995	3. TIME OF DEATH 6:25 P.M.			
4. SOCIAL SECURITY NUMBER 219-01-1708			5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		7. DATE OF BIRTH (Month, Day, Year) Sept 2, 1899	8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Frederick		9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT										
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Clarksburg				10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO				
10e. STREET AND NUMBER 12733 Lewisdale Road				10f. ZIP CODE 20871			10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES 			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: Black			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Farmer			16b. KIND OF BUSINESS/INDUSTRY Farming				
17. FATHER'S NAME (First, Middle, Last) Nathan Orem						18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Holsey				
19a. INFORMANT'S NAME (Type/Print) Dorothy J. Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12733 Lewisdale Road, Clarksburg, Maryland 20871						
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Grove Cemetery			DATE 6/9	20c. LOCATION — City or Town, State Damascus, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Casper L. Williams			22. NAME AND ADDRESS OF FACILITY Olin L. Molesworth, P.A., Funeral Home 26401 Ridge Road, Damascus, Maryland							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dementia of Alzheimer's Type DUE TO (OR AS A CONSEQUENCE OF): years Approximate interval Between Onset and Death b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Deconditioning										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO
27. MANNER OF DEATH 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide			26a. DATE OF INJURY (Month, Day, Year) 	26b. TIME OF INJURY M 1 □ YES 2 □ NO	26c. INJURY AT WORK? 	26d. DESCRIBE NOW INJURY OCCURRED 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 			28b. LOCATION (Street and Number or Rural Route Number, City or Town, State) 	
29a. CERTIFIER 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Casper E. Cline III, M.D.						29c. LICENSE NUMBER D16428		29d. DATE SIGNED (Month, Day, Year) 6/8/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) Casper E. Cline III, M.D. 300 W. 9th Street, Frederick, Maryland										
31. DATE FILED (Month, Day, Year) JUN 12 1995	32. REGISTRAR'S SIGNATURE Jahn Davidson-Parkell									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

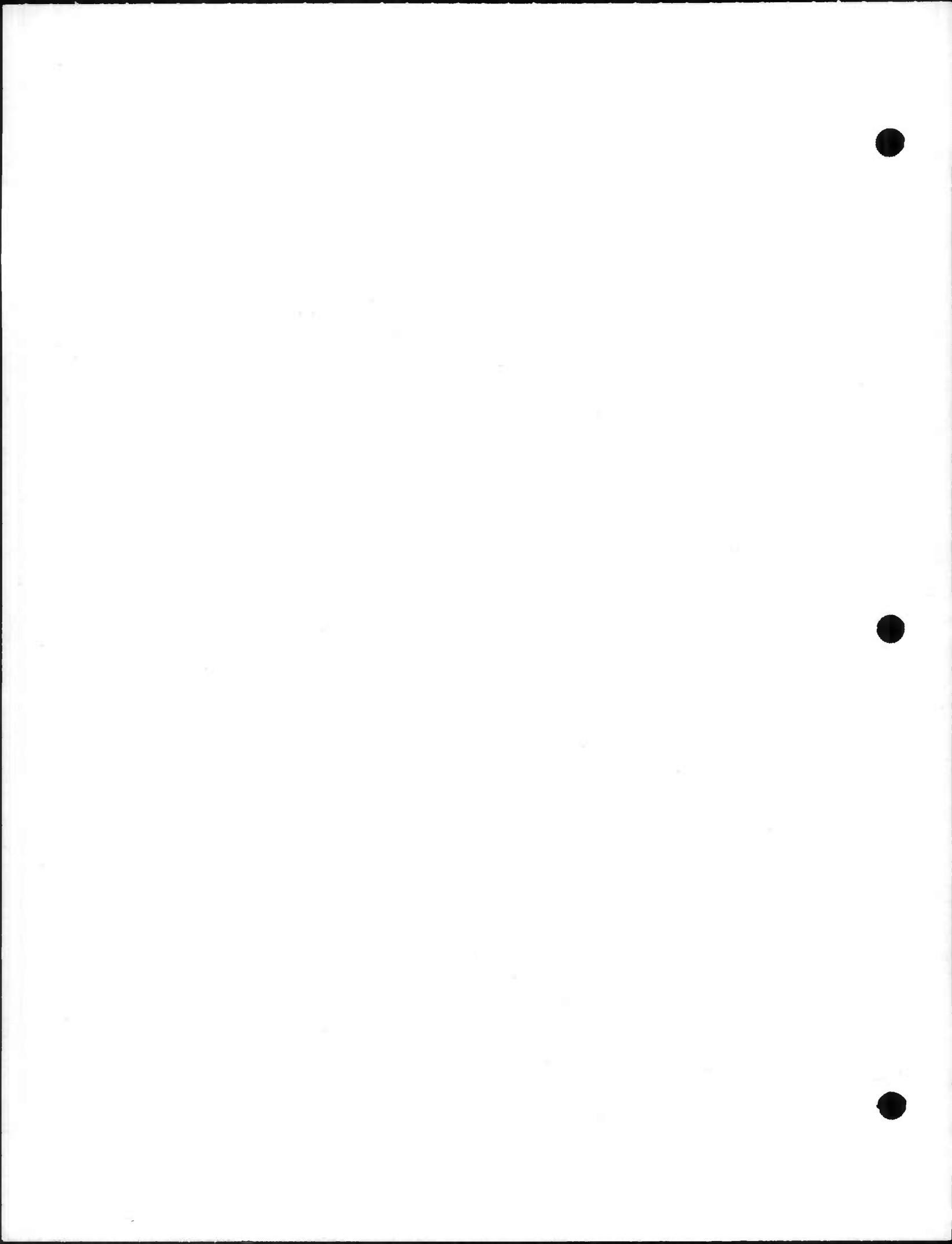
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19142

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Lilien Piekarz</i>						2. DATE OF DEATH MONTH 6 DAY 2 YEAR 95	3. TIME OF DEATH 1:20 P.M.	
4. SOCIAL SECURITY NUMBER 118-24-4098		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) 5/21/34		8. BIRTHPLACE (State or Foreign Country) NEW YORK
9a. FACILITY NAME (if not institution, give street and number) <i>Holy Cross Hospital</i>			9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring, MD</i>			9c. COUNTY OF DEATH <i>Montgomery</i>		
10a. STATE MD		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION <i>Silver Spring</i>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1813 Snowdrop Lane</i>				10f. ZIP CODE 20906			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 PROGRAM ASSISTANT			16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) HERMAN LEITNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) JEAN WEINSTOCK				
19a. INFORMANT'S NAME (Type/Print) ROLF PIEKARZ (HUSBAND)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1813 SNOWDROP LANE - SILVER SPRING, MARYLAND 20906					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) MT. LEBANON CEMETERY			DATE 6/6	20c. LOCATION — City or Town, State ADELPHI, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Rolf L. Thomas</i>								
22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE-ROCKVILLE, MARYLAND 20852								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								
a. CARDIAC TAMPOONADE DUE TO (OR AS A CONSEQUENCE OF): 12 HRS								
b. MALIGNANT PERICARDIAL EFFUSION DUE TO (OR AS A CONSEQUENCE OF): 8 DAYS								
c. CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF): 4 MOS								
d.								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide								
28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								
28d. DESCRIBE HOW INJURY OCCURRED								
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan J. Kermayer, MD</i>								
29c. LICENSE NUMBER D19170								
29d. DATE SIGNED (Month, Day, Year) ► 6-2-95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN J. KERMAYER 10313 GEORGIA AVE. SILVER SPRING, MD 20902								
31. DATE FILED (Month, Day, Year) JUN 07 1995								
32. REGISTRAR'S SIGNATURE <i>John D. Parker</i>								



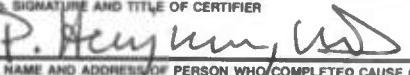
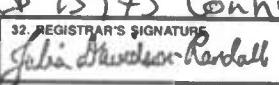
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR						3. TIME OF DEATH						
BETTY ANN PRIDHAM			05 30 95						6:55A M						
4. SOCIAL SECURITY NUMBER			5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)				
578-40-7584			<input type="checkbox"/> M <input checked="" type="checkbox"/> F		67 YRS.		MONTHS		DAYS		HOURS		YEAR		
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH						
MONTGOMERY GENERAL HOSPITAL			OLNEY						MONTGOMERY						
RESIDENCE OF DECEASED															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
MD.		MONTGOMERY		SILVER SPRING											
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?							
3322 CHISWICK CT. #612E		20906						U.S.A.							
11. MARITAL STATUS			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE						
1 Elementary/Secondary (0-12)			2 College (1-4 or 5+)			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY						
ROBERT CLIFT McKIMMIE			2 CLERK			F.B.I.									
17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Maiden Surname)												
JOSEPH F. PRIDHAM			ANN LYNCH												
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
JOSEPH F. PRIDHAM			SAME AS ITEM #10												
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE			20c. LOCATION — City or Town, State						
			SAINT MARYS CEMETERY 6/3/1995						PISCATAWAY, MD.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 															
22. NAME AND ADDRESS OF FACILITY			20910 W. W. CHAMBERS CO. INC., SILVER SPRING, MD.												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
<p>a. <u>Multilobar Pneumonia with Septicemia</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <u>Neurogenic Swallowing Disorder</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <u>Progressive Neuromuscular Rigidity</u> DUE TO (OR AS A CONSEQUENCE OF): (etiology Not Defined)</p>															
Approximate Interval Between Onset and Death															
1 month															
3 months															
4 months															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
<p>Type II Diabetes Mellitus Adverse Reaction to Prolixin</p> <p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/></p>															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one)						27. MANNER OF DEATH						
			HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA						OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. LICENSE NUMBER D35045												
29b. SIGNATURE AND TITLE OF CERTIFIER 			29d. DATE SIGNED (Month, Day, Year) ► 5-30-95												
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)			31. DATE FILED (Month, Day, Year) JUN 01 1995												
PAUL HENRUM, MD 13975 Connecticut Ave #308 SS, MD 20926			32. REGISTRAR'S SIGNATURE 												

$\gamma^{(2)} = \lambda_0$

$\alpha = \beta$

$\beta = \gamma$

$\alpha = \beta$

$\alpha = \beta$

β

$\alpha = \beta$

$\alpha = \beta$ $\beta = \gamma$ $\gamma = \delta$ $\delta = \epsilon$ $\epsilon = \zeta$ $\zeta = \eta$ $\eta = \theta$ $\theta = \varphi$ $\varphi = \psi$ $\psi = \omega$ $\omega = \nu$ $\nu = \mu$ $\mu = \lambda$ $\lambda = \kappa$ $\kappa = \sigma$ $\sigma = \tau$ $\tau = \rho$ $\rho = \omega$ $\omega = \alpha$

$\alpha = \beta$ $\beta = \gamma$ $\gamma = \delta$ $\delta = \epsilon$ $\epsilon = \zeta$ $\zeta = \eta$ $\eta = \theta$ $\theta = \varphi$ $\varphi = \psi$ $\psi = \omega$ $\omega = \nu$ $\nu = \mu$ $\mu = \lambda$ $\lambda = \kappa$ $\kappa = \sigma$ $\sigma = \tau$ $\tau = \rho$ $\rho = \omega$ $\omega = \alpha$

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

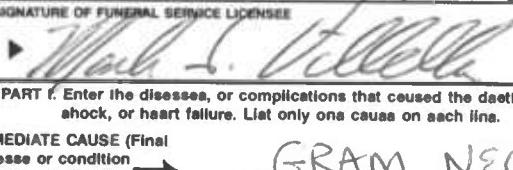
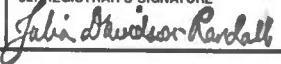
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

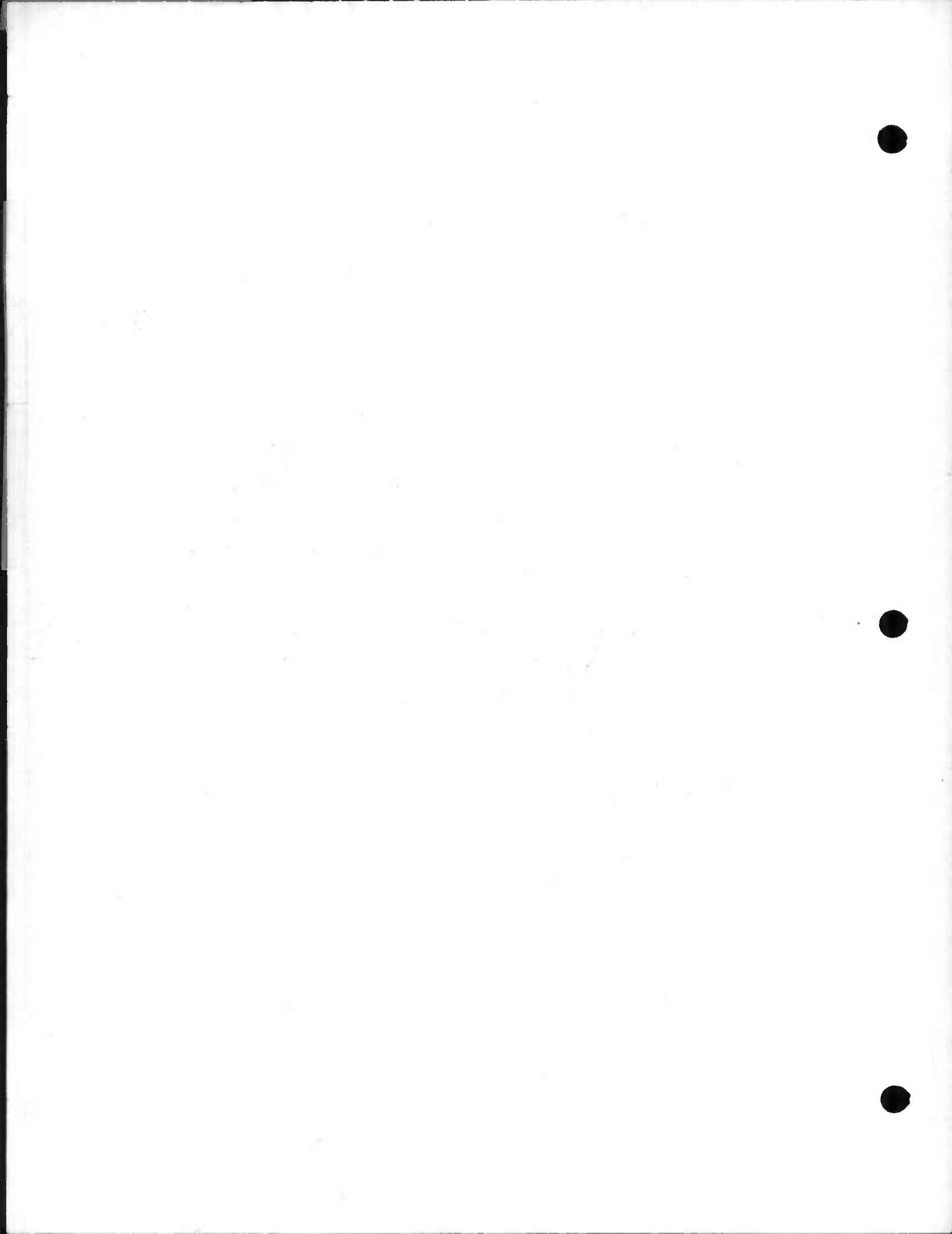
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19144

1. DECEASED'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
Edward Shelton Payne						June 3, 1995	10:12 A. M.	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		
213-45-9398		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	49 YRS.	MONTHS	DAYS	HOURS	MINS.	
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH					
Washington Adventist Hospital			Takoma Park					
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				
Maryland		Montgomery		Silver Spring				
10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?	
1911 Stratton Road				20910			U.S.A.	
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced								
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12)		College (1-4 or 5+) 5+			Architect Independent Contractor			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)				
Marvin R. Payne				Lucie Edna Rupp				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Linda L. Payne		1 Pennydog Court Silver Spring, Maryland 20902						
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. LOCATION — City or Town, State			
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metropolitan Crematory 6/4/95			Alexandria, Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY						
		Francis J. Collins Funeral Home, Inc. 500 University Blvd. W. Sil. Spr. MD 20901						
23. PART f. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. GRAM NEGATIVE SEPTICEMIA</p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. ASCITES</p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. ALCOHOLIC CIRRHOSIS</p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. ALCOHOLISM</p>								
<p>Approximate Interval Between Onset and Death 2 DAYS</p>								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
COAGULOPATHY RENAL FAILURE				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			27. MANNER OF DEATH			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D35087			29d. DATE SIGNED (Month, Day, Year) ► 6/3/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
Joseph GENOVESE, Jr. M.D. 2121 MEDICAL PARK DR. SILVER SPRING, MD. 20902								
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE 						
JUN 05 1995								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

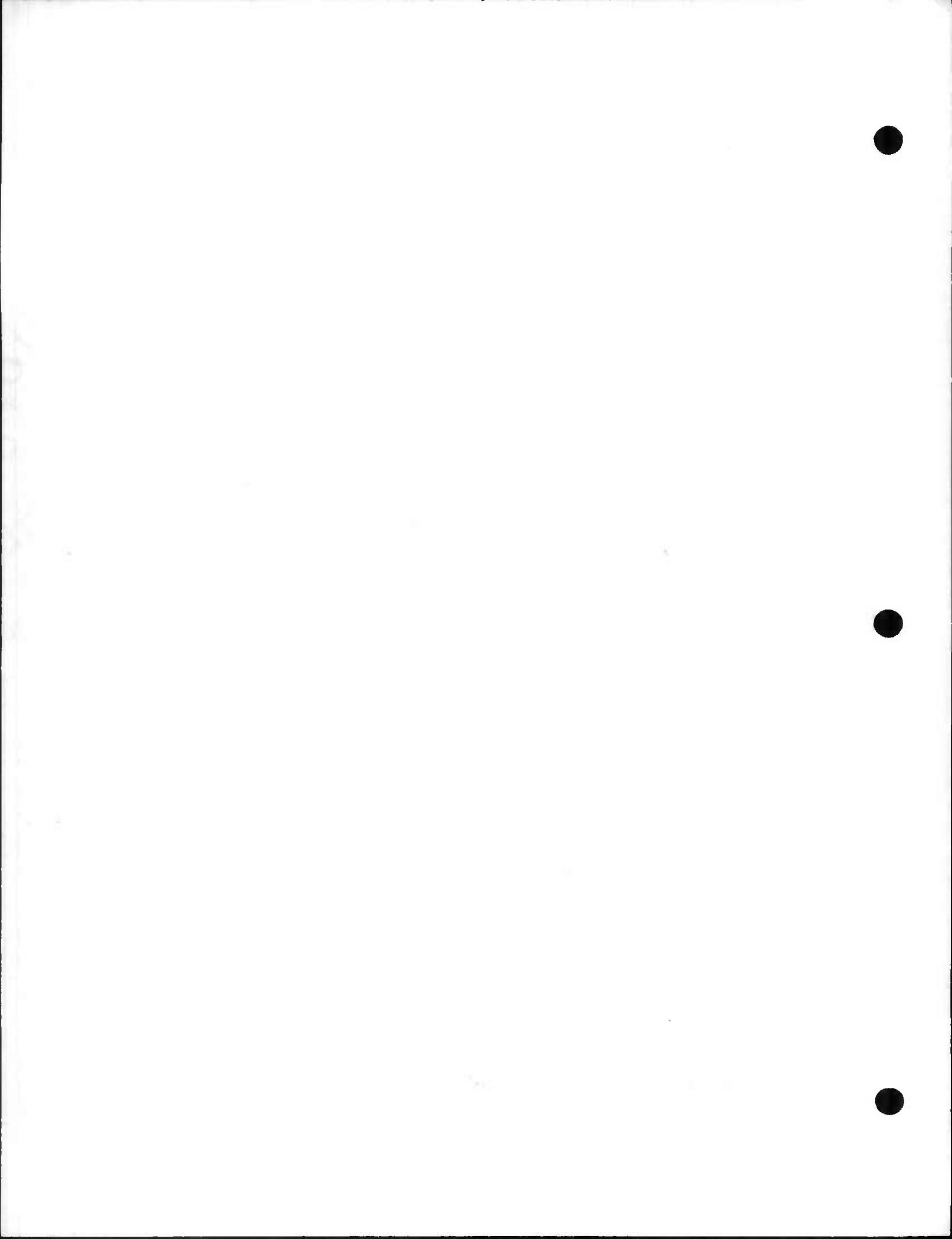
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 9 1995								3. TIME OF DEATH M 10 PM									
1. DECEDENT'S NAME (First, Middle, Last) William Cletus Pyle																			
4. SOCIAL SECURITY NUMBER 216-03-7066		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH Month, Day, Year Feb. 21, 1907		8. BIRTHPLACE (State or Foreign Country) Penna.									
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace									
RESIDENCE OF DECEDENT 10e. STATE PA 10b. COUNTY York 10c. CITY, TOWN OR LOCATION Delta										10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER 413 Main Street										10f. ZIP CODE 17314									
10g. CITIZEN OF WHAT COUNTRY? USA																			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW 2				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify:									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fireman				16b. KIND OF BUSINESS/INDUSTRY Civil Service													
17. FATHER'S NAME (First, Middle, Last) William C. Pyle										18. MOTHER'S NAME (First, Middle, Maiden Surname) Octavia Bennington									
19a. INFORMANT'S NAME (Type/Print) Olive M. Pyle										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 413 MAin St., Delta, PA., 17314									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Slate Ridge				DATE 6/13/95		20c. LOCATION — City or Town, State Delta, PA.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John H. Tillet										22. NAME AND ADDRESS OF FACILITY Harkins F.H. Inc., Delta, PA, 17314									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Ruptured AAA with bleeding about 4h.										Approximate Interval Between Onset and Death									
b. Abdominal Aortic Aneurysm DUE TO (OR AS A CONSEQUENCE OF): arteriosclerotic Cardio Vascular disease.																			
c. DUE TO (OR AS A CONSEQUENCE OF):																			
d. DUE TO (OR AS A CONSEQUENCE OF):																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Abdominal Aortic Aneurysm.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <table border="0"><tr><td><input type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td></td></tr><tr><td><input type="checkbox"/> Suicide</td><td><input type="checkbox"/> Could not be determined</td></tr><tr><td><input type="checkbox"/> Nomicide</td><td></td></tr></table>										<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED	
<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																		
<input type="checkbox"/> Accident																			
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																		
<input type="checkbox"/> Nomicide																			
28e. PLACE OF INJURY — At home, farm, street, factory, office										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER M. J. Esq. M.D. Surgeon 29c. LICENSE NUMBER 105515502 ► 6-9-55 29d. DATE SIGNED (Month, Day, Year)																	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. J. Esq. M.D., 433 Girard St. Tedd, MD. 21078																			
31. DATE FILED (Month, Day, Year) JUN 12 1995										32. REGISTRAR'S SIGNATURE Jahn Dawson Marshall									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

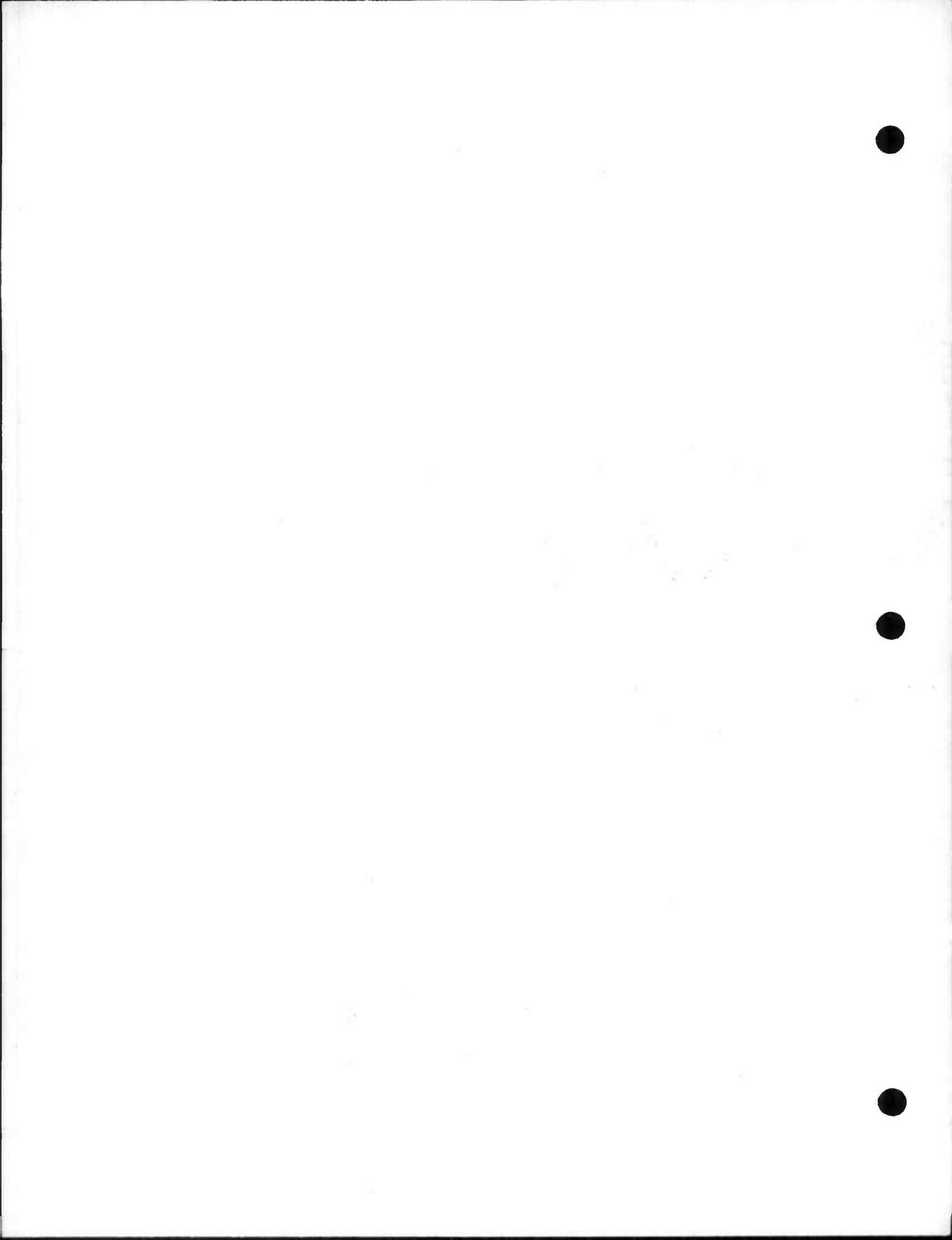
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - FOR STATE REGISTRAR		1. DECEDENT'S NAME (First, Middle, Last) <i>Lawrence Joseph Peters</i>								2. DATE OF DEATH MONTH DAY YEAR JUNE 9 1995		3. TIME OF DEATH 12:39A M			
4. SOCIAL SECURITY NUMBER 577-07-9605		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 16, 1904		8. BIRTHPLACE (State or Foreign Country) Baltimore			
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Fallston								9c. COUNTY OF DEATH Harford					
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 726 Linwood Avenue		10f. ZIP CODE 21014								10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)				16b. KIND OF BUSINESS/INDUSTRY Real Estate									
17. FATHER'S NAME (First, Middle, Last) Henry (U/K) Peters		18. MOTHER'S NAME (First, Middle, Maiden Surname) Veronica (U/K) (U/K)													
19a. INFORMANT'S NAME (Type/Print) Bernita F. Peters		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 726 Linwood Avenue, Bel Air, Maryland 21014													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Highview Memorial Gardens 6-12-95				DATE		20c. LOCATION — City or Town, State Fallston, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard K. McComas III</i>												22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, MD 21009			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate interval Between Onset and Death 14 Hrs			
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Gastro Intestinal Bleeding</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Diverticular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i></p>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hemorrhagic Shock ASCVD</i>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Franz C. Vella Camilleri, M.D.</i>		29c. LICENSE NUMBER P 21207				29d. DATE SIGNED (Month, Day, Year) ► JUNE 9 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Franz C. Vella Camilleri, M.D.		31. DATE FILED (Month, Day, Year) JUN 13 1995													
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>															



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

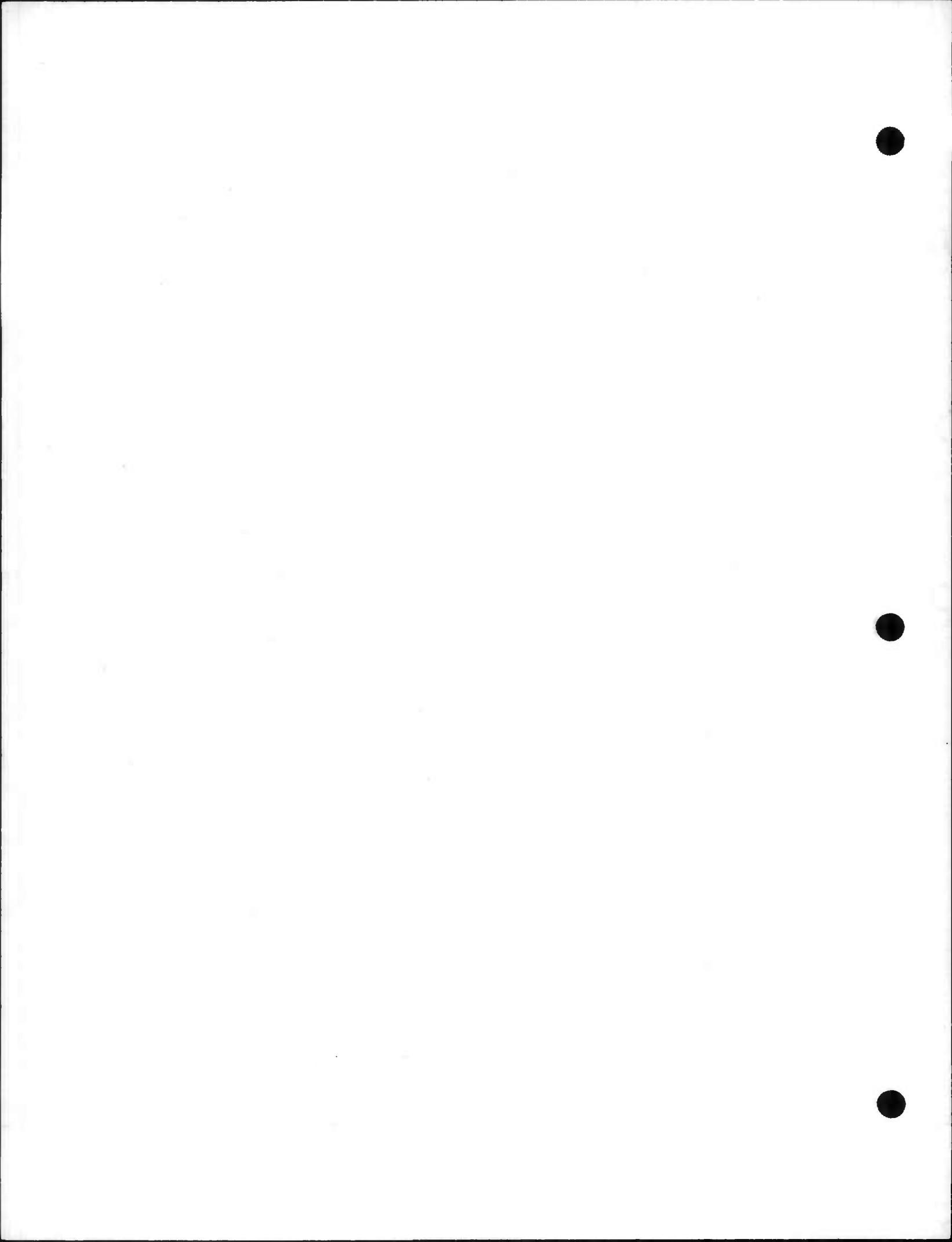
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) FRANCES ELIZABETH PYLES											2. DATE OF DEATH MONTH JUNE DAY 6 YEAR 1995	3. TIME OF DEATH 9:20 P.M.	
4. SOCIAL SECURITY NUMBER 214-07-2821		5. SEX M	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) FEB. 27, 1916		8. BIRTHPLACE (State or Foreign Country) WEST VIRGINIA			
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL & MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY					
RESIDENCE OF DECEDENT													
10a. STATE WEST VA	10b. COUNTY MINERAL	10c. CITY, TOWN OR LOCATION FT. ASHBY				10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
10e. STREET AND NUMBER BAKER HOLLOW ROAD				10f. ZIP CODE 26719				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input checked="" type="checkbox"/>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Specify: WHITE				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY HOME									
17. FATHER'S NAME (First, Middle, Last) WILBUR E. PYLES				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE J. HINDS									
19a. INFORMANT'S NAME (Type/Print) WAYNE D. WOLFORD				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O.BOX 64 - FT. ASHBY, WV 26719									
20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. ASHBY CEMETERY		20c. LOCATION — City or Town, State FT. ASHBY, WV									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Wendy J. Tschirch</i>				22. NAME AND ADDRESS OF FACILITY FT. ASHBY FUNERAL HOME, INC. P.O.BOX 1260-FT. ASHBY,WV 26719									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): b. SEIZURE DISORDER DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):													
Approximate Interval Between Onset and Death 4 days													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>									
25. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
26. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DQA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		26c. DATE OF INJURY (Month, Day, Year)				26d. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		26e. INJURY AT WORK? M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		26f. DESCRIBE HOW INJURY OCCURRED	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. DATE OF INJURY (Month, Day, Year)		28c. TIME OF INJURY		28d. INJURY AT WORK?		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julie Poonai M.D.</i>				29c. LICENSE NUMBER D 36766				29d. DATE SIGNED (Month, Day, Year) JUN 07 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIK POONAI M.D., 155 FREDERICK ST., CUMBERLAND, MD 21502													
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE <i>Julie Poonai M.D.</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

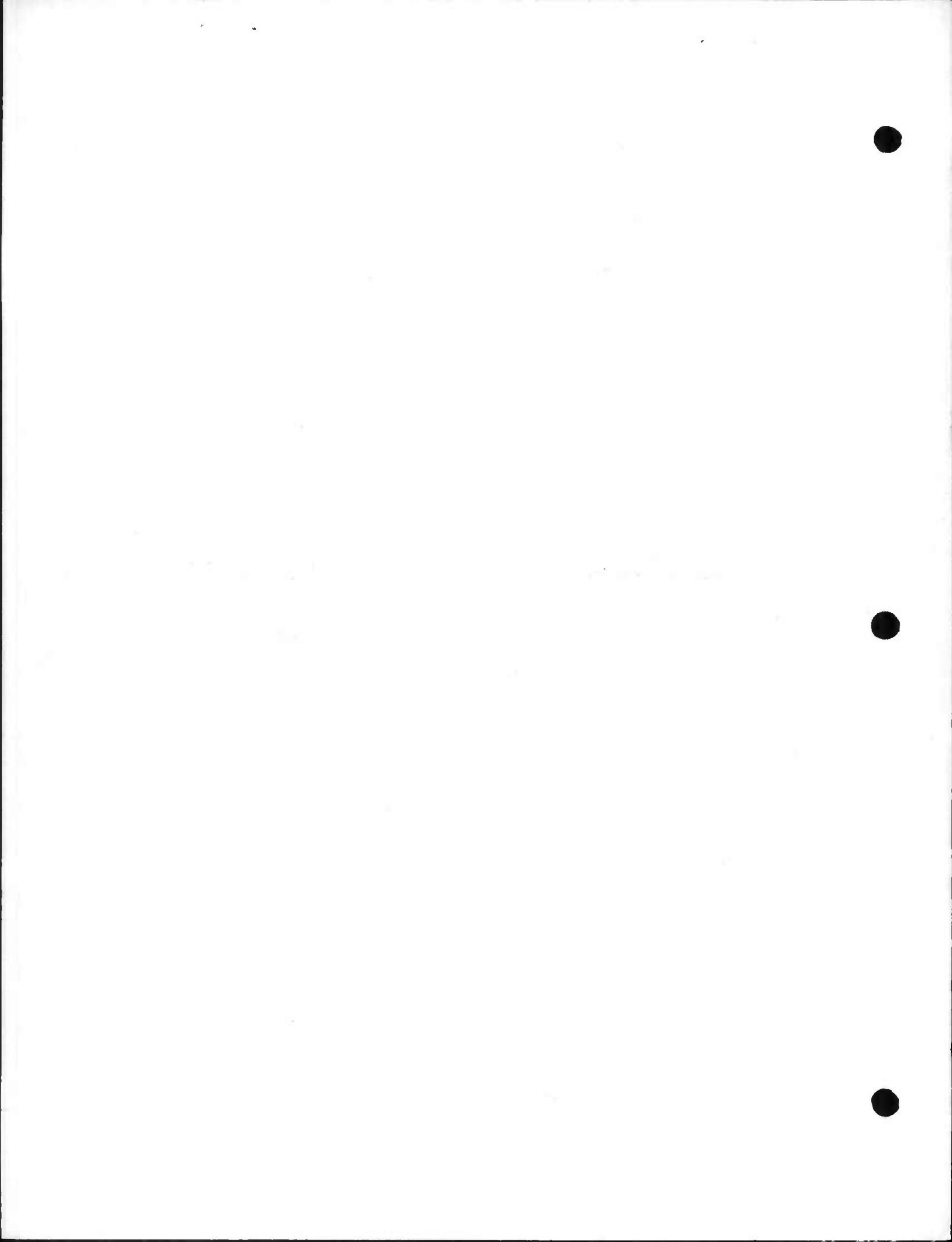
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1.	FOR STATE REGISTRAR														
1.	DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH	3. TIME OF DEATH		
	Edna Lillian Parks											MONTH DAY YEAR	7:30 A M		
4.	SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign Country)					
	214-48-6262		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	94 YRS.	MONTHS		DAYS HOURS MIN.		Month, Day, Year	Maryland					
9a.	FACILITY NAME (If not institution, give street and number)											9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH		
	302 Talbot Avenue											Cambridge	Dorchester		
RESIDENCE OF DECEDENT															
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION											10d. INSIDE CITY LIMITS?	
Maryland	Dorchester		Cambridge											<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER												10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?		
	302 Talbot Avenue											21613	US		
11. MARITAL STATUS	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES											13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	14. RACE — American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced															
15. DECEDENT'S EDUCATION (Specify only highest grade completed)	Elementary/Secondary (0-12)		College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY									
	8				Homemaker										
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)														
Charles Webster Phillips	Sara Simmons														
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
Frances P. Brooks	111 Choptank Terrace Cambridge, Maryland 21613														
20a. METHOD OF DISPOSITION	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)											DATE	20c. LOCATION — City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify):	Green Lawn Cemetery											6/10	Cambridge, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE	22. NAME AND ADDRESS OF FACILITY														
	Thomas Funeral Home, P.A. 700 Locust St. Cambridge, Maryland 21613														
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE = Severe											4 Years			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	CHRONIC LEUKEMIA														
25. WAS CASE REFERRED TO MEDICAL EXAMINER?	26. PLACE OF DEATH (Check only one)											24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH	1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED						
	2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide		3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined		4 <input type="checkbox"/> Could not be determined										
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)														
29a. CERTIFIER (Check only one)	1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER	Mahmood Shariff											29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
	103 Aurora Street Cambridge, MD 21613											D15765		► 6/8/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
Mahmood Shariff	103 Aurora Street Cambridge, MD 21613														
31. DATE FILED (Month, Day, Year)	32. REGISTRAR'S SIGNATURE														
JUN 19 1995															

95 19148



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

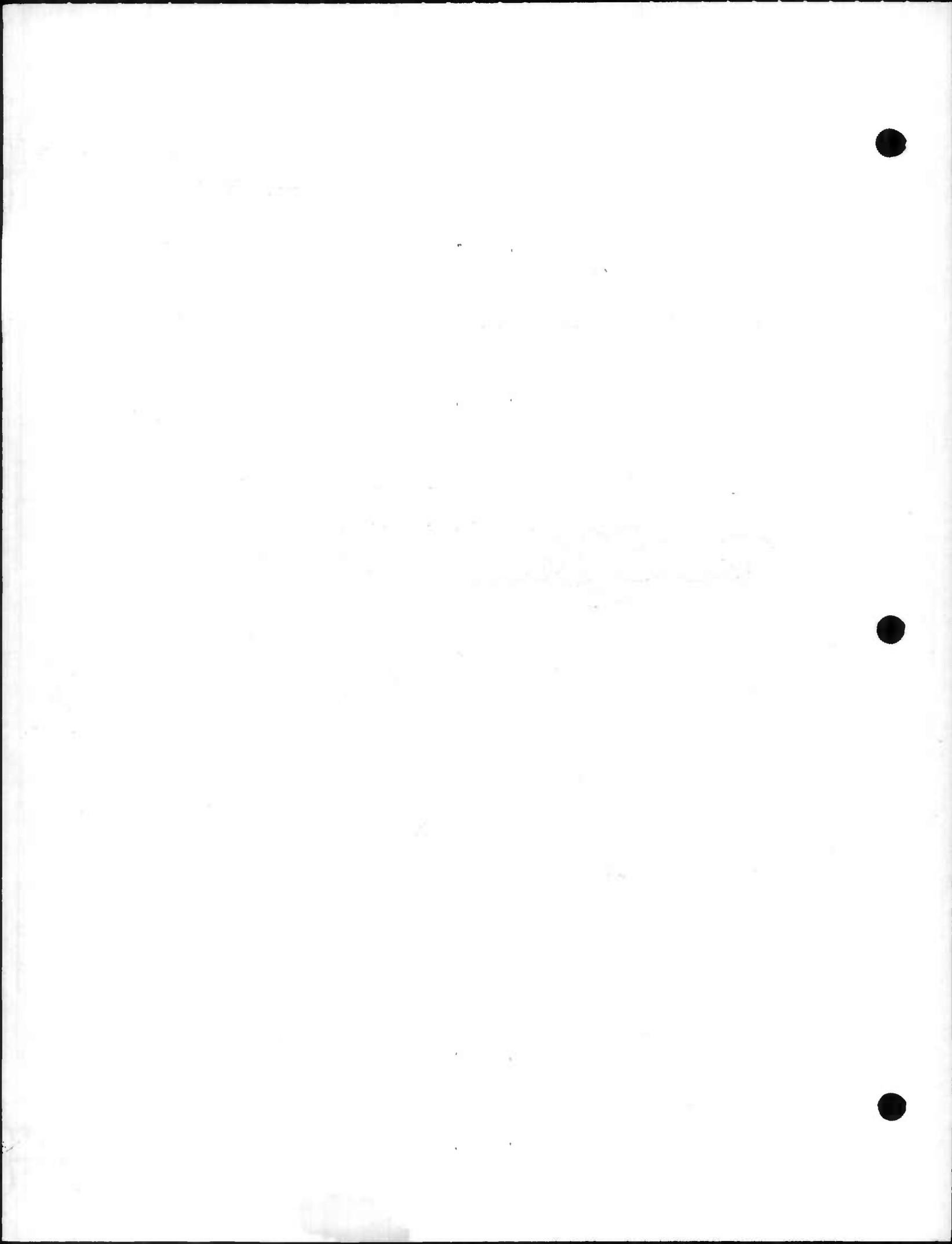
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR									3. TIME OF DEATH	
William Bernard Powers			June 14 1995 0242 AM										
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 51 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) July 27, 1943			8. BIRTHPLACE (State or Foreign Country) PA		
235-64-8112				MONTHS	DAYS	HOURS	MIN.						
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown									9c. COUNTY OF DEATH Washington	
Washington County Hospital													
RESIDENCE OF DECEDENT													
10a. STATE MD	10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Clear Spring									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12738 Spickler Road			10f. ZIP CODE 21722									10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Parts Clerk			16b. KIND OF BUSINESS/INDUSTRY Retail Automotive							
17. FATHER'S NAME (First, Middle, Last) Judson Powers			18. MOTHER'S NAME (First, Middle, Maiden Surname) Geraldine Sipes										
19a. INFORMANT'S NAME (Type/Print) Constance A. Powers			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12738 Spickler RD. Clear Spring, MD 21722										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Seven Dolors Cemetery 6/16/95			DATE	20c. LOCATION — City or Town, State Clearville, PA						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Roger S. Powers</i>			22. NAME AND ADDRESS OF FACILITY Grove Funeral Home P.O. Box 368 Hancock, MD 21750										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Auto myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):													
b. <i>Operative Salvage attempt at right leg</i> MINUTES DUE TO (OR AS A CONSEQUENCE OF): reversed suture													
c. <i>Severe atherosclerotic peripheral vascular disease</i> DAYS DUE TO (OR AS A CONSEQUENCE OF): last 5 years													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Infective distal Right leg wound</i>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WEBE-AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Karl P. Riggle, M.D.</i>			29c. LICENSE NUMBER D38764			29d. DATE SIGNED (Month, Day, Year) ► 6/11/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Karl P. Riggle, M.D. 11113 Medical Campus Rd Suite 100 Hagerstown MD 21742												DHMH-18 Rev 1/89	
31. DATE FILED (Month, Day, Year) JUN 23 1995			32. REGISTRAR'S SIGNATURE <i>Julia A. Wilson-Randall</i>										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: This law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

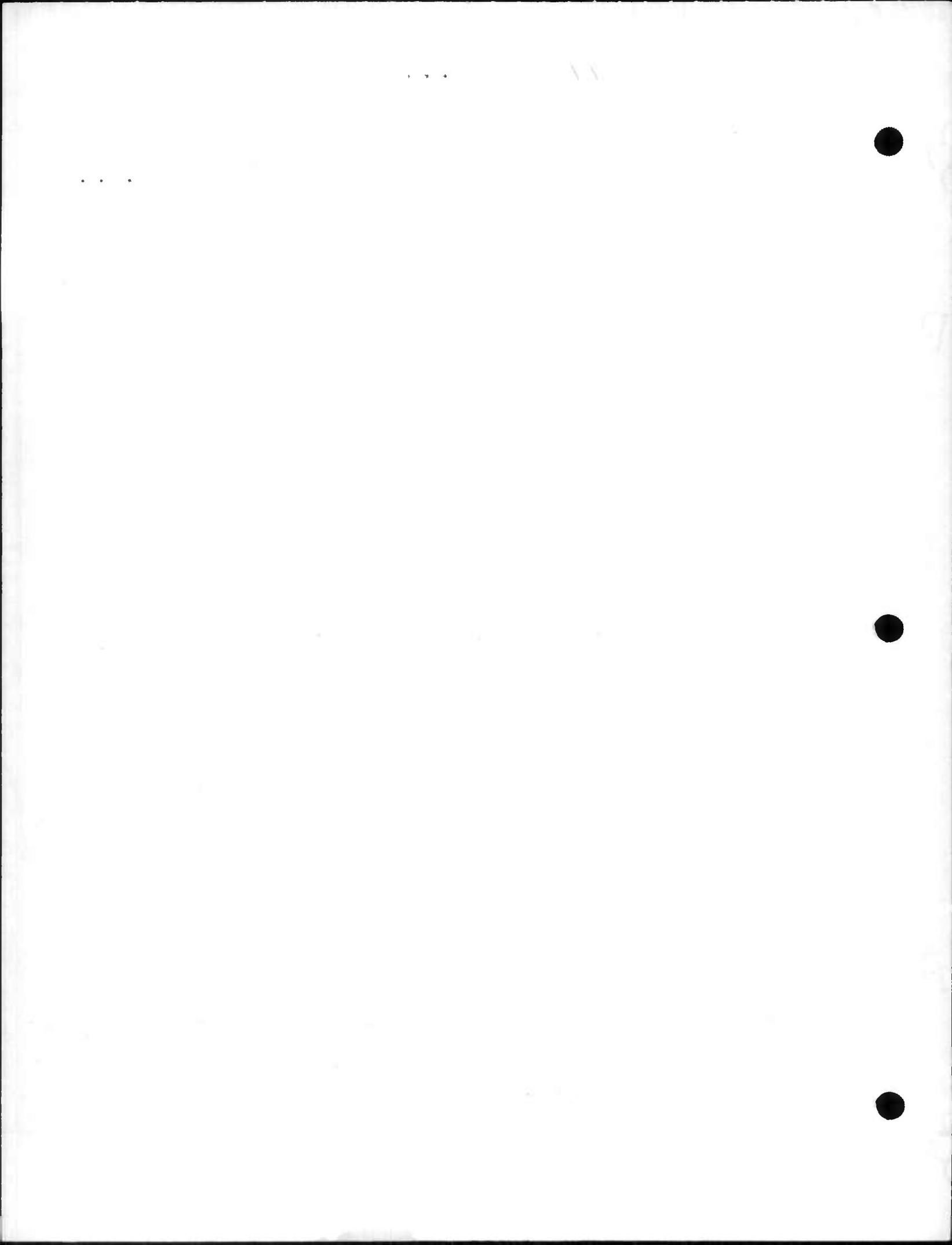
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

AMENDED #8 6/2/95 ELM P.G.C.		95 19150	
FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH	
		REG. NO.	
<p>1. DECEDENT'S NAME (First, Middle, Last) <i>Russell Leon Perry</i></p> <p>2. DATE OF DEATH <i>May 30, 1995</i></p> <p>3. TIME OF DEATH <i>3:00 PM</i></p> <p>4. SOCIAL SECURITY NUMBER <i>577 30 0170</i></p> <p>5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>6. AGE (In yrs. last birthday) <i>68</i> YRS. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.</p> <p>7. DATE OF BIRTH <i>7-16-20</i> (Month, Day, Year)</p> <p>8. BIRTHPLACE (State or Foreign Country) <i>North Carolina USA</i></p>			
<p>9a. FACILITY NAME (If not institution, give street and number) <i>1410 Iverson St. # 202</i></p> <p>9b. CITY, TOWN OR LOCATION OF DEATH <i>Oxon Hill</i></p> <p>9c. COUNTY OF DEATH <i>Prince George's</i></p>			
<p>RESIDENCE OF DECEDENT</p> <p>10a. STATE <i>MARYLAND</i></p> <p>10b. COUNTY <i>P.G.</i></p> <p>10c. CITY, TOWN OR LOCATION <i>Oxon Hill</i></p> <p>10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>			
<p>10e. STREET AND NUMBER <i>1410 Iverson St. # 202</i></p> <p>10f. ZIP CODE <i>20745</i></p> <p>10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i></p>			
<p>11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> <p>12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WW II</i></p> <p>13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:</p> <p>14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i></p>			
<p>15. DECEDENT'S EDUCATION (Specify only highest grade completed)</p> <p>Elementary/Secondary (8-12) College (14 or 5+)</p> <p>12th</p>		<p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Researcher</i></p> <p>16b. KIND OF BUSINESS/INDUSTRY <i>United Planning Organ.</i></p>	
<p>17. FATHER'S NAME (First, Middle, Last) <i>Russell Perry</i></p> <p>18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mabel Lyles</i></p>			
<p>19a. INFORMANT'S NAME (Type/Print) <i>Vancie A. Perry</i></p>		<p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1700 Calais Ct., Oxon Hill, Md. 20745</i></p>	
<p>20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)</p>		<p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glenwood Cem.</i></p> <p>DATE <i>6/3/95</i></p> <p>20c. LOCATION — City or Town, State <i>Wash., D.C.</i></p>	
<p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dawn H. Pratt</i></p>		<p>22. NAME AND ADDRESS OF FACILITY <i>H.S. Washington & Sons, inc. 4925 Burroughs Ave., N.E.</i></p>	
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Diabetes hypertension arteriosclerotic cardiovascular disease</i></p> <p>DUE TO (OR AS A CONSEQUENCE OF): <i>years</i></p> <p>Approximate Interval Between Onset and Death</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>			
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></p>			
<p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>26. PLACE OF DEATH (Check only one)</p> <p>HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)</p>	
<p>27. MANNER OF DEATH</p> <p>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</p>		<p>28a. DATE OF INJURY (Month, Day, Year)</p> <p>28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED</p> <p>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p>	
<p>29a. CERTIFIER (Check only one)</p> <p>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p>			
<p>29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusta P. Rodriguez MD</i></p>		<p>29c. LICENSE NUMBER <i>D21280</i></p>	
<p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusta P. Rodriguez MD, 5009 Rayburn Ct. Op. Sp. 1. Md 20748</i></p>		<p>29d. DATE SIGNED (Month, Day, Year) <i>May 30, 1995</i></p>	
<p>31. DATE FILED (Month, Day, Year) <i>JUN 05 1995</i></p>		<p>32. REGISTRAR'S SIGNATURE <i>Sabina Jackson-Roddell</i></p>	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

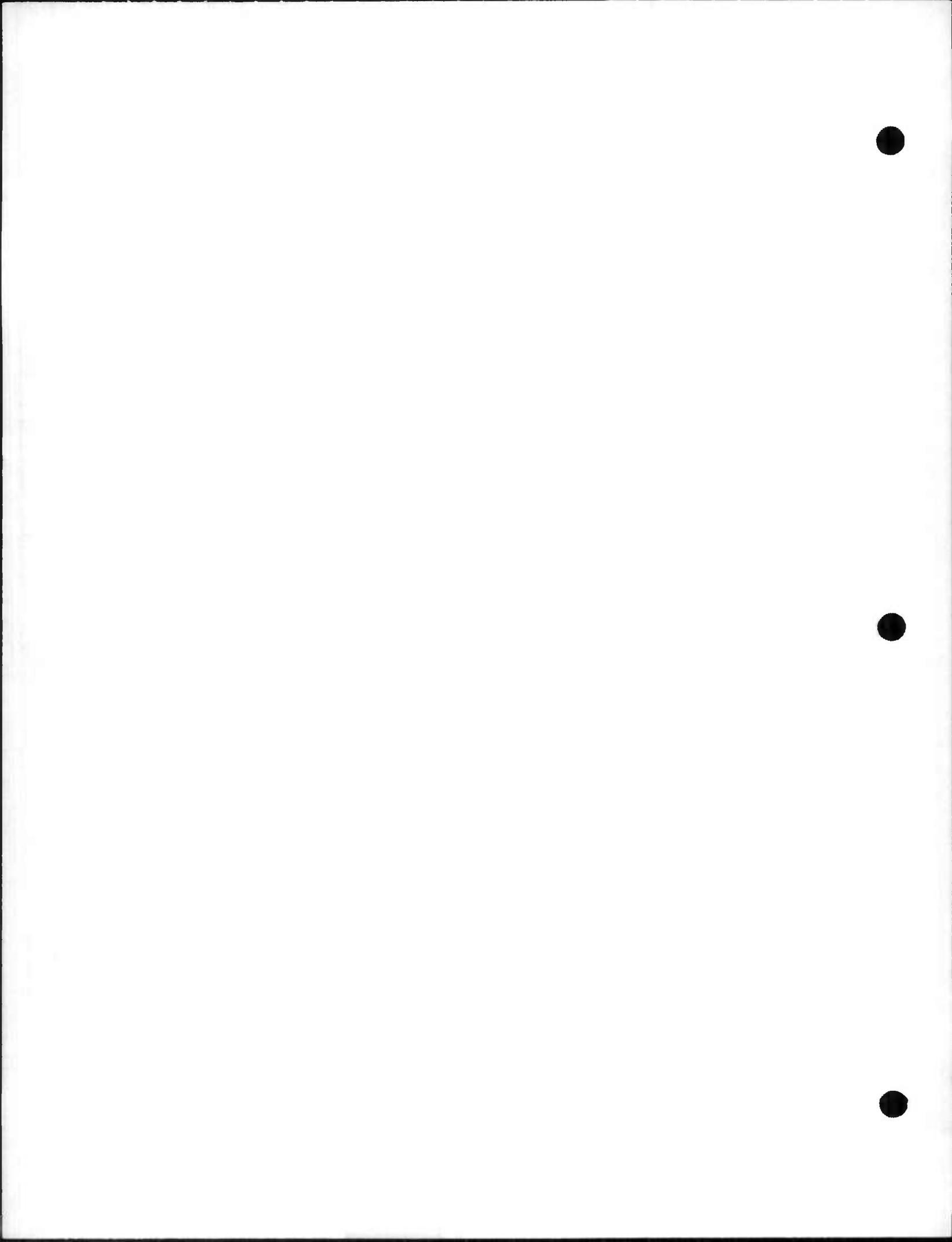
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Stanley M. Petrone										June 5, 1995	3:00 P. M.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
579-18-2354		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	82 YRS.	MONTHS	DAYS	HOURS	MIN.			Nov. 15, 1912	Washington, DC
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Greenbelt Nursing Home										Greenbelt	Prince George's
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Maryland		Prince George's		Mount Rainier							
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
4609 25th Street, Apt. #4										20712	United States
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)		Supervisor				Oil Industry					
12											
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Pietro Petrone										Pauline Saginario	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Mary Petrone										3203 Kimberly Road, Hyattsville, MD 20782	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
		Fort Lincoln Cemetery				6/9/95		Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ►										22. NAME AND ADDRESS OF FACILITY	
										Fort Lincoln Funeral Home, Inc.	
										3401 Bladensburg Rd., Brentwood, MD 20722	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Minutes	
a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):											
b. Metastatic Cancer of Liver DUE TO (OR AS A CONSEQUENCE OF):										6 Months	
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Jacobs		29c. LICENSE NUMBER D34722		29d. DATE SIGNED (Month, Day, Year) ► 6-6-95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
Dr. Poochikian, 5632 Annapolis Road, Bladensburg, Maryland 20710											
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE John Henderson-Randall									



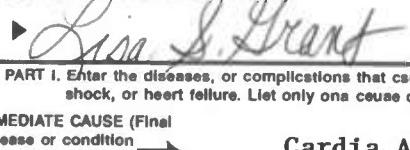
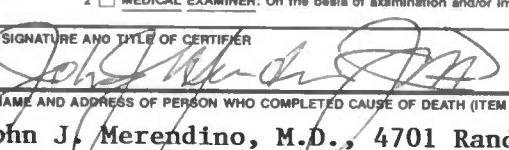
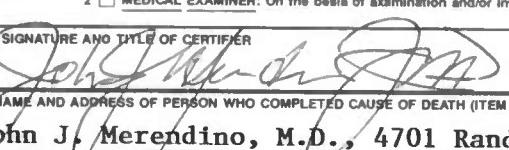
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

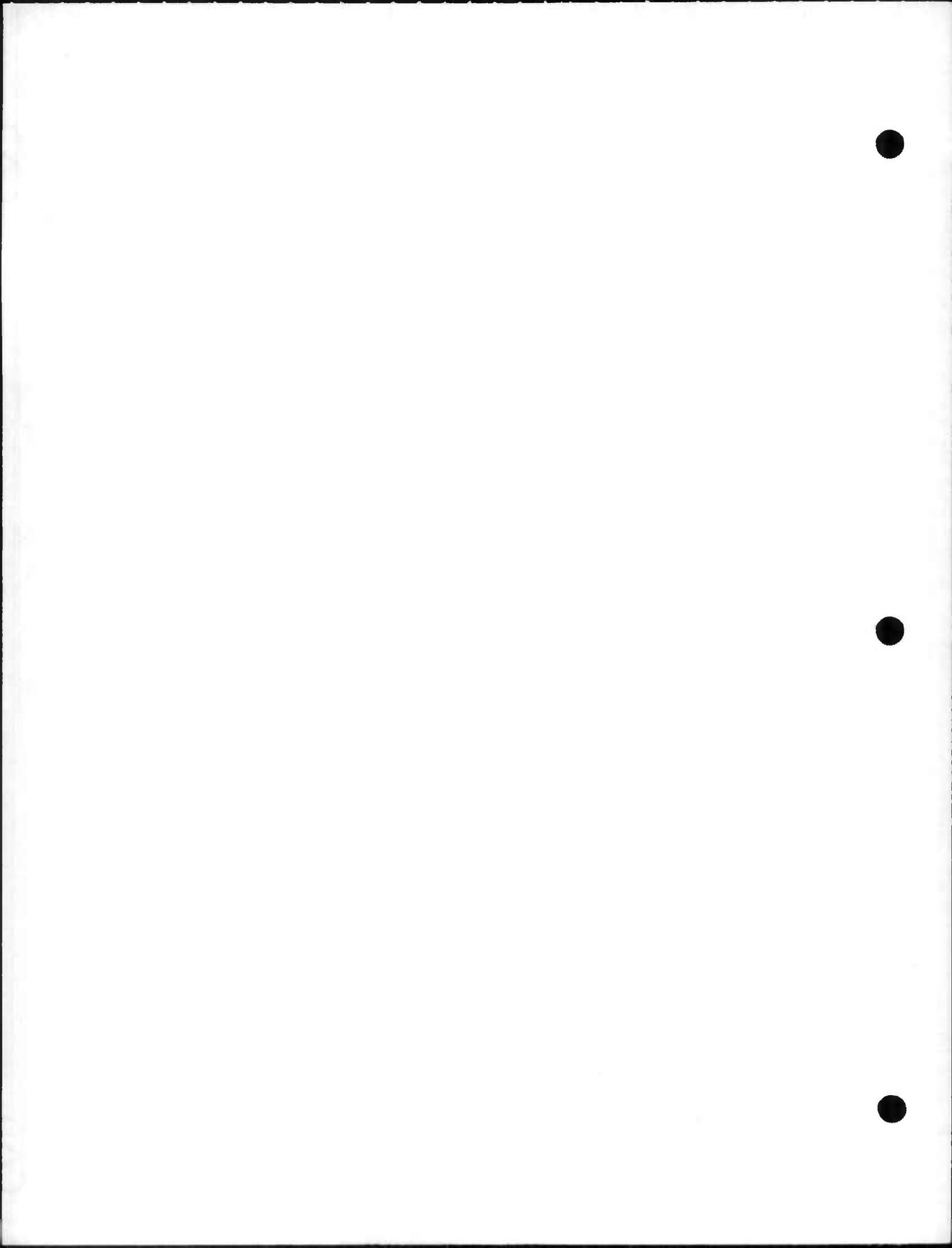
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

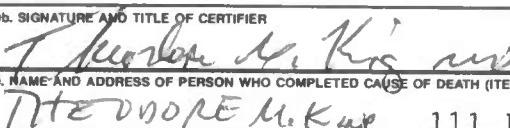
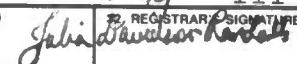
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
ALICE ROSA PROFFITT										JUNE 3, 1995	4:30 P.M.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
578-54-7710		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	97 YRS.	MONTHS	DAY	HOURS	MIN.	July 14, 1897		Georgia	
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	
Carriage Hill Nursing Home										Silver Spring	
RESIDENCE OF DECEDENT										9c. COUNTY OF DEATH	
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
NA	NA	Washington, D.C.									
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1329 Longfellow Street, N.W.										20011	United States
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)		College (1-4 or 5+) 2				Actuarial Assistant				Federal Government	
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Paul Pulliam Proffitt										Alice Maddox	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Louise Proffitt										9505 Thornhill Road, Silver Spring, MD 20901	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
		Fort Lincoln Cemetery				6/8/95		Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Arrest										Minutes	
a. DUE TO (OR AS A CONSEQUENCE OF):											
b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):										Years	
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia, Severe Cutaneous Ulceration of Legs										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)									
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide											
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year)  6/5/95			
29c. SIGNATURE AND TITLE OF CERTIFIER  John J. Merendino, M.D., 4701 Randolph Road, Rockville, Maryland 20852								29c. LICENSE NUMBER D36046			
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 									
										DNMN-18 Rev 1/89	

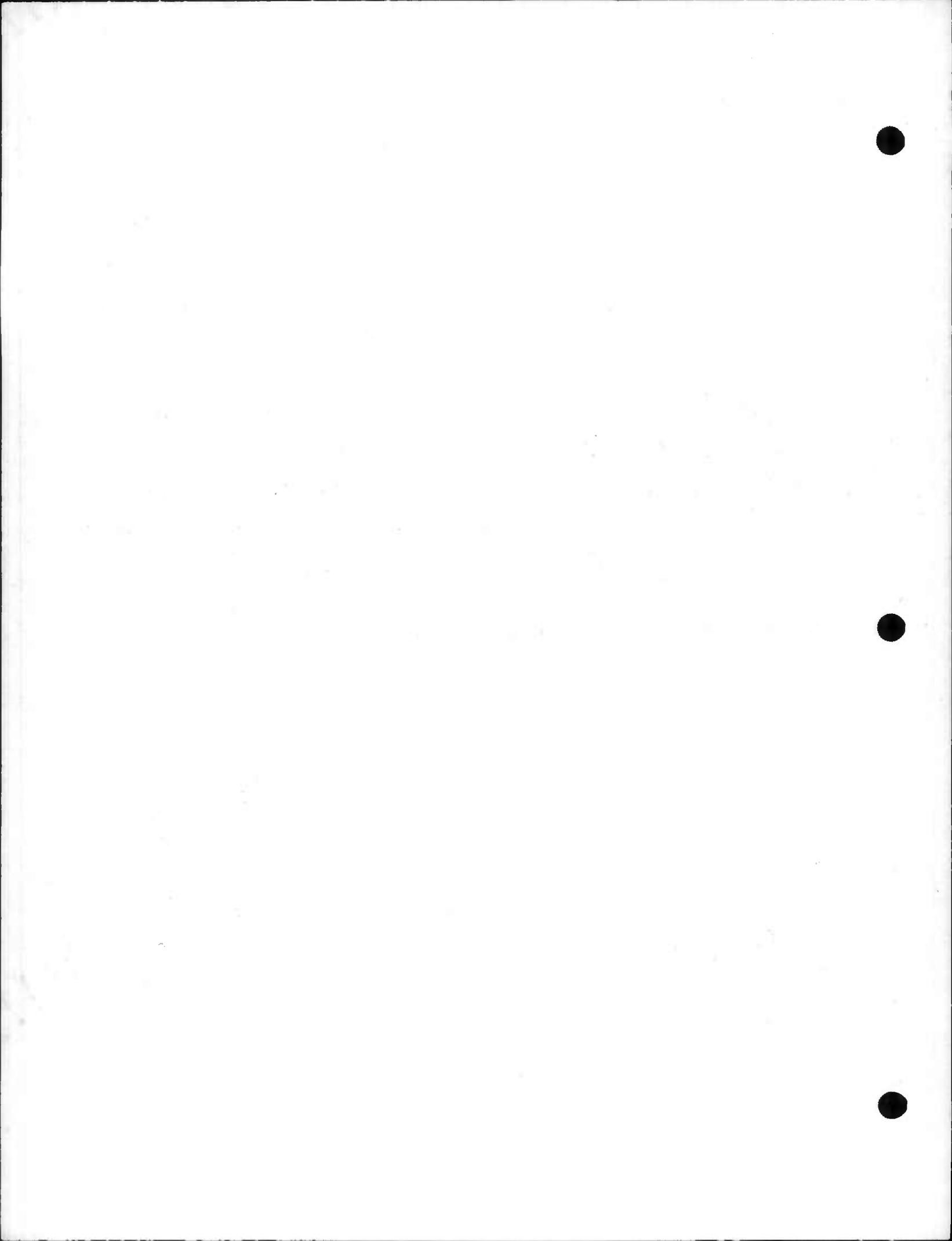


95 19153

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 1:13A M	
JEROME A. PHILPOTT												MAY 26 1995		
4. SOCIAL SECURITY NUMBER 579-94-6037		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 28 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.									
9a. FACILITY NAME (If not institution, give street and number) 2007 SPAULDING AVE.												7. DATE OF BIRTH (Month, Day, Year) JAN. 25 1967	8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA	
9b. CITY, TOWN OR LOCATION OF DEATH SUITLAND												9c. COUNTY OF DEATH PRINCE GEORGES		
RESIDENCE OF DECEDENT														
10e. STATE MD	10b. COUNTY PRINCE GEORGE	10c. CITY, TOWN OR LOCATION SUITLAND										10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 2007 SPARLING AVNUE					10f. ZIP CODE 20746					10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PLUMBER			16b. KIND OF BUSINESS/INDUSTRY HESS MECHANIC									
17. FATHER'S NAME (First, Middle, Last) LUCIOUS PHILPOTT					18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH CRAWFORD									
19a. INFORMANT'S NAME (Type/Print) ANN V. PHILPOTT (WIFE)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2007 SPARLING AVNUE, SUITLAND, MD 20746									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLENWOOD CEMETERY					DATE JUNE 3 95	20c. LOCATION — City or Town, State WASHINGTON, D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY W.H. BACON FUNERAL HOME INC. 3447 14TH STREET, N.W. WASH, D.C. 20010									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Multiple Gunshot Wounds</i> DUE TO (OR AS A CONSEQUENCE OF):														
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined					28a. DATE OF INJURY (Month, Day, Year) 5/25/95	28b. TIME OF INJURY 2320 M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED <i>subject shot</i>						
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) home					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2007 Spaulding Avenue									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) ► MAY 26, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. Karp 111 PENN STREET, BALTIMORE, MARYLAND 21201.					31. DATE FILED (Month, Day, Year) JUN 05 1995					32. REGISTRAR'S SIGNATURE 				



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

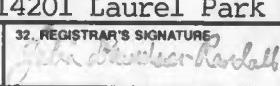
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19154

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Harry Edwin Phebus				June 12 1995 2:20 a.m.	
4. SOCIAL SECURITY NUMBER 219 - 03 - 4372		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Laurel		7. DATE OF BIRTH (Month, Day, Year) Dec 21, 1903	
RESIDENCE OF DECEDENT 10a. STATE Maryland		10b. COUNTY Howard		8. BIRTHPLACE (State or Foreign Country) Maryland	
10c. CITY, TOWN OR LOCATION Savage		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		9c. COUNTY OF DEATH Prince George	
10e. STREET AND NUMBER 8279 Woodward Street		10f. ZIP CODE 20763		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor		16b. KIND OF BUSINESS/INDUSTRY State Highway Administration	
17. FATHER'S NAME (First, Middle, Last) Charles Edwin Phebus		18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Wright			
19a. INFORMANT'S NAME (Type/Print) Joanne Phebus Bond		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8279 Woodward Street, Savage, Maryland 20763			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) METRO Crematory, Inc.		DATE 6/13	20c. LOCATION — City or Town, State Catonsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
<ul style="list-style-type: none"> a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): b. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ 					
Approximate Interval Between Onset and Death 5 days					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D43237		29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Armstrong 14201 Laurel Park Drive #102, Laurel, Maryland 20707					
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE 			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

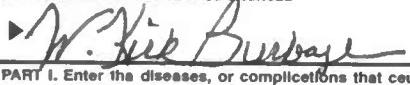
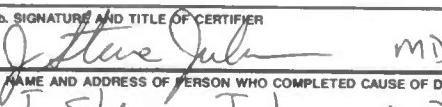
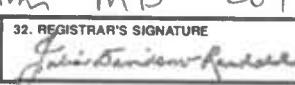
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

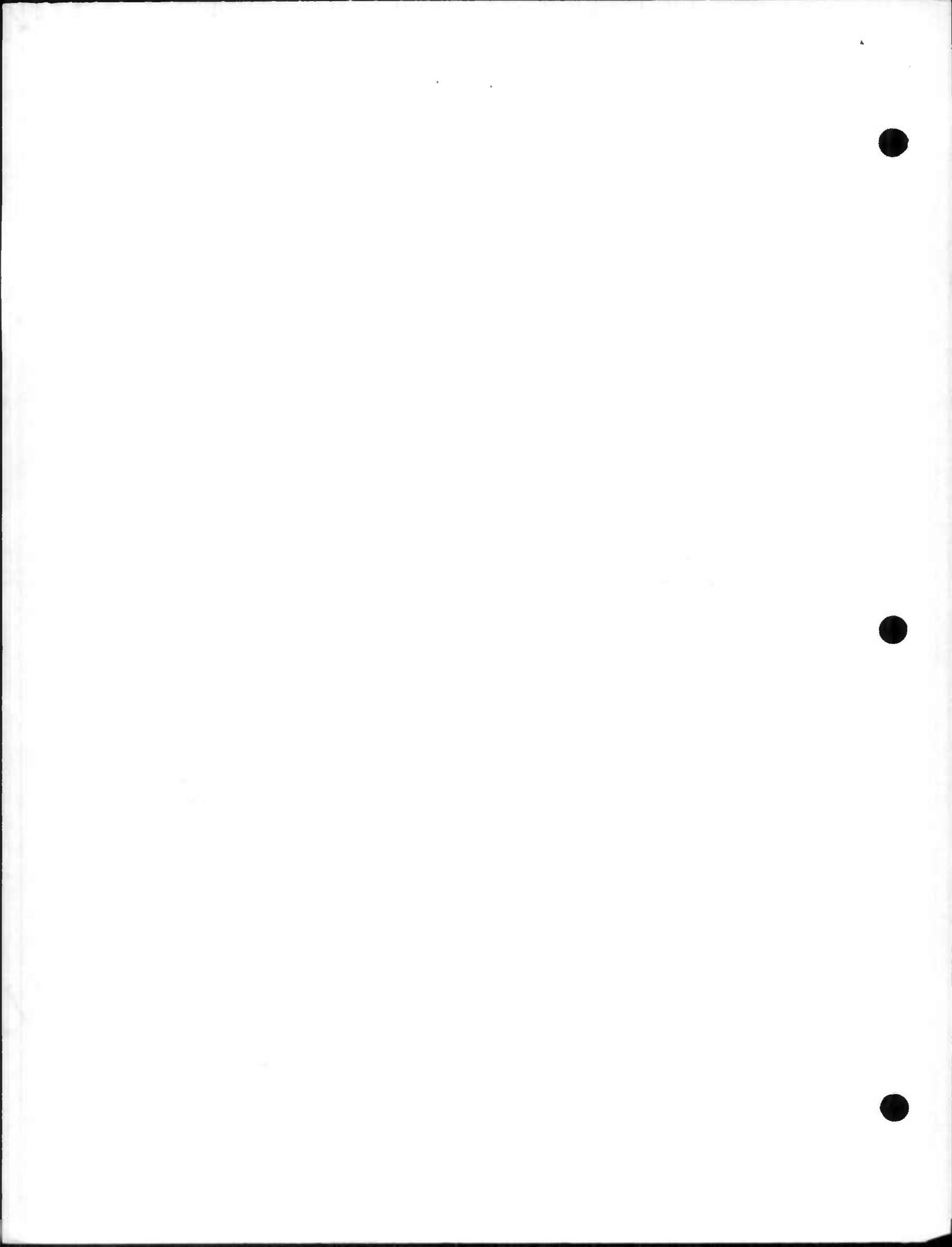
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19155

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
		1. DECEDENT'S NAME (First, Middle, Last)		Kenneth James		Phillips		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 0343 M			
		4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 2/1/37			
		9a. FACILITY NAME (If not Institution, give street and number)		PENINSULA REGIONAL MEDICAL CENTER						9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
		RESIDENCE OF DECEDENT											
		10a. STATE MD		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Pittsville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		10e. STREET AND NUMBER 7225 Sixty Foot RD				10f. ZIP CODE 21850				10g. CITIZEN OF WHAT COUNTRY? USA			
		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1954-1957		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white					
		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Life Insurance							
		17. FATHER'S NAME (First, Middle, Last) William Andrew Phillips				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Surgeoner							
		19e. INFORMANT'S NAME (Type/Print) Mary Jane Phillips				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7225 Sixty Foot RD Pittsville, MD 21850							
		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION /Name of cemetery, crematory or other place/ Phillips Cemetery		DATE 6/8/95		20c. LOCATION — City or Town, State Showell, MD					
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Burbage Funeral Home 108 Williams st. Berlin, MD 21811							
		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death: 14hr											
		b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 041813		29d. DATE SIGNED (Month, Day, Year) ► 6/5/95							
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Steve Julian MD 201 Pine Bluff Rd Salisburry MD 21801											
		31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE 									



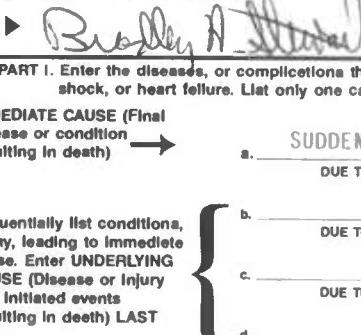
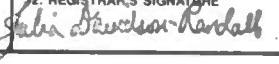
ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/6/95 t.t.

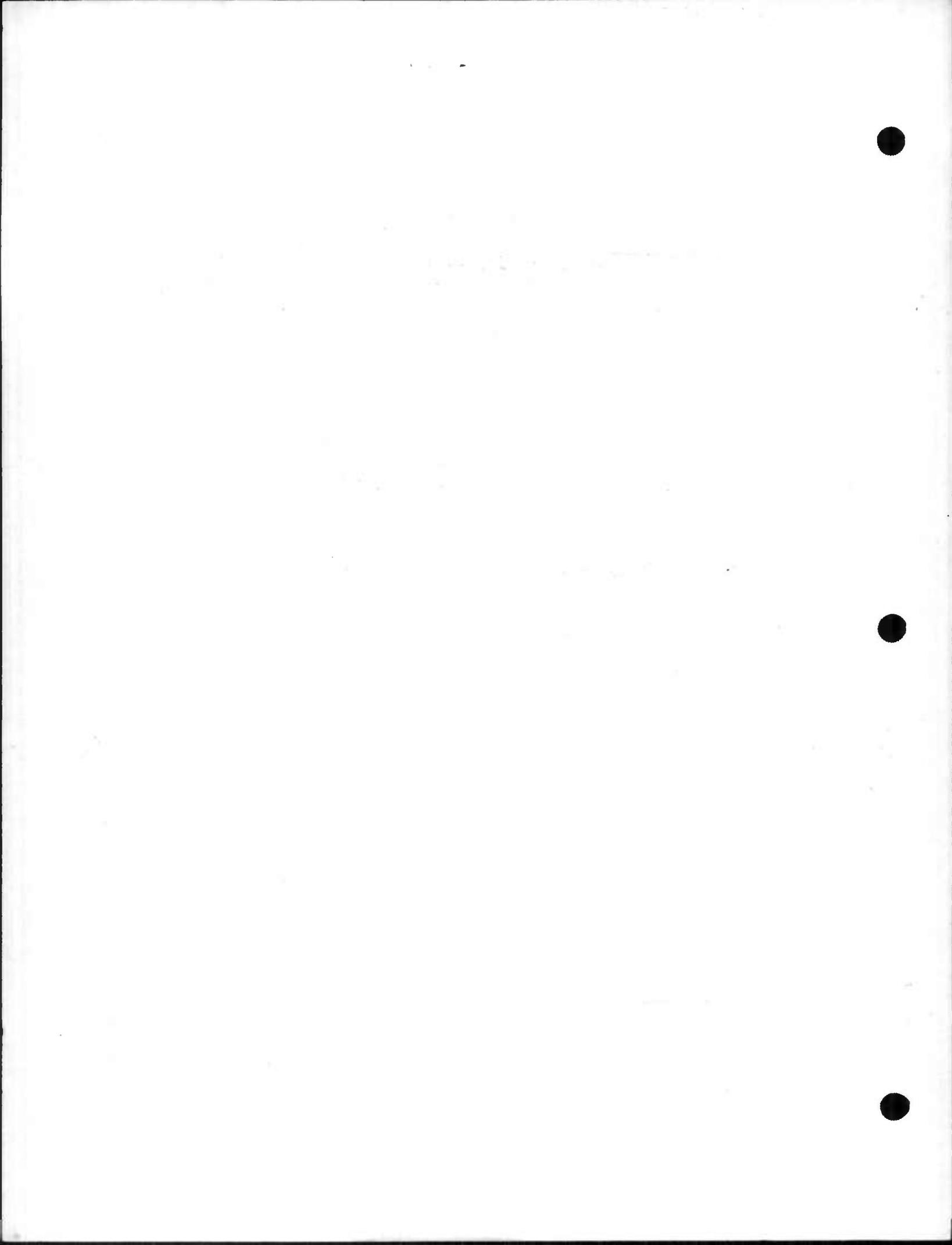
95 19156

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH
CRYSTAL LOUISE PILKERTON		JUNE 11, 1995		10:05 AM
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday) YRS.	7. DATE OF BIRTH (Month, Day, Year)
None		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	IF UNDER 1 YEAR MONTHS 1 DAYS 28 HOURS MIN.	Apr. 16, 1995
8a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		10. BIRTHPLACE (State or Foreign Country)
GARRETT COUNTY MEMORIAL HOSPITAL		OAKLAND		Maryland
RESIDENCE OF DECEDENT				
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
MD	Garrett	Oakland		
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?
Rt. 6, Box 1121-B		21550		USA
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMEED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
				14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) None		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Infant		16b. KIND OF BUSINESS/INDUSTRY

17. FATHER'S NAME (First, Middle, Last) (UNKNOWN)		18. MOTHER'S NAME (First, Middle, Maiden Surname) Crystal Louise Mann		
19a. INFORMANT'S NAME (Type/Print) Crystal L. Shiflett		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 6, Box 1121-B, Oakland, Maryland 21550		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ashby Cemetery		DATE 20c. LOCATION — City or Town, State 6/13 Oakland, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 32 S. Second St., Oakland, MD 21550		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUDDEN INFANT DEATH SYNDROME (SIDS) DUE TO (OR AS A CONSEQUENCE OF):				
b. DUE TO (OR AS A CONSEQUENCE OF):				
c. DUE TO (OR AS A CONSEQUENCE OF):				
d. DUE TO (OR AS A CONSEQUENCE OF):				
Approximate Interval Between Onset and Death				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 28d. DESCRIBE NOW INJURY OCCURED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		
29c. LICENSE NUMBER O.C.M.E		29d. DATE SIGNED (Month, Day, Year) ► JUNE 12, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201				
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE 		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

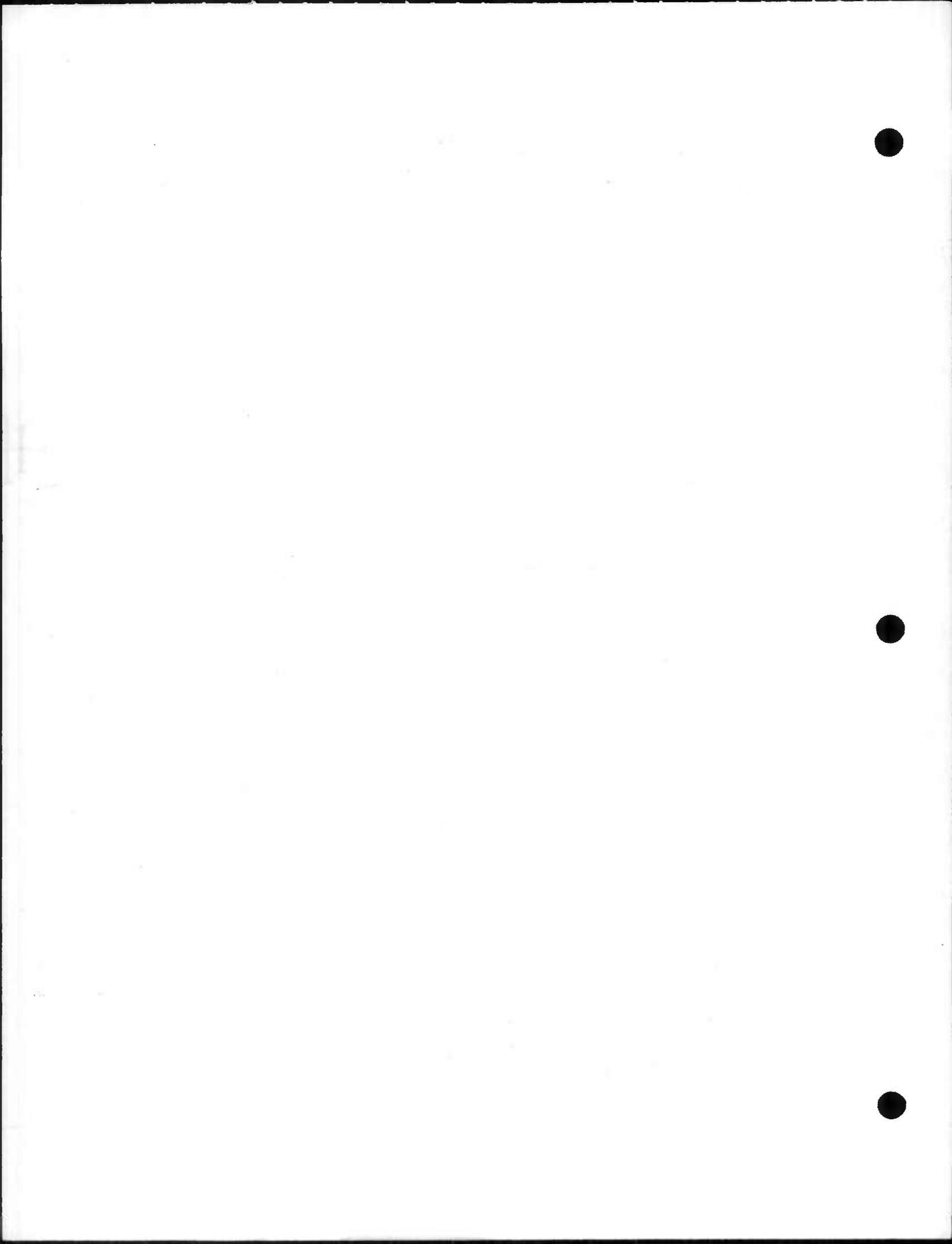
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)		ALAN WAYNE RAUTIO								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 1326p m	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
468-40-3775		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		57 YRS.		MONTHS		DAYS		HOURS		MIN.	
9e. FACILITY NAME (If not institution, give street and number)		Shady Grove Adventist Hospital								9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
										Rockville		Montgomery	
RESIDENCE OF DECEDENT													
10e. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland		Montgomery		Gaithersburg									
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?			
5 Duvall Lane		20877								United States			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1965-1967				13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
1 Elementary/Secondary (0-12)		16a. DECEDENT'S EDUCATION (Specify only highest grade completed) College (1-4 or 5+)				16b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Business Consultant				16c. KIND OF BUSINESS/INDUSTRY Chemical Industry			
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)											
Waino Theodore Rautio		Esther Iria Pakarinen											
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Marilyn W. Rautio		5 Duvall Lane, Gaithersburg, Maryland 20877											
20e. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Metropolitan Crematory				6/10		Alexandria, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY											
		DeVol Funeral Home 10 E. Deer Park Dr., Gaithersburg, MD 20877											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
<p>b. <i>Cardiac Arrest</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i>Acute Myocardial Infarction</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i>Atherosclerotic Heart Disease</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small></p>													
Approximate Interval Between Onset and Death <i>Minutes</i>													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
<p>{</p> <p>c. <i>Chronic Hypertension</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i>Diabetes Mellitus</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i>Obesity</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small></p>													
Approximate Interval Between Onset and Death <i>Years</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
HOSPITAL: <input checked="" type="checkbox"/>		OTHER: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)											
29e. CERTIFIER (Check only one)		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29g. SIGNATURE AND TITLE OF CERTIFIER <i>Edward Wilson M.D.</i>		29c. LICENSE NUMBER <i>01953</i>		29d. DATE SIGNED (Month, Day, Year) <i>June 6, 1995</i>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year) <i>JUN 08 1995</i>											
Edward E. Wilson 9901 Medical Ctr. Dr Rockville, MD 20857		32. REGISTRAR'S SIGNATURE <i>Jane Dawson-Kordell</i>											



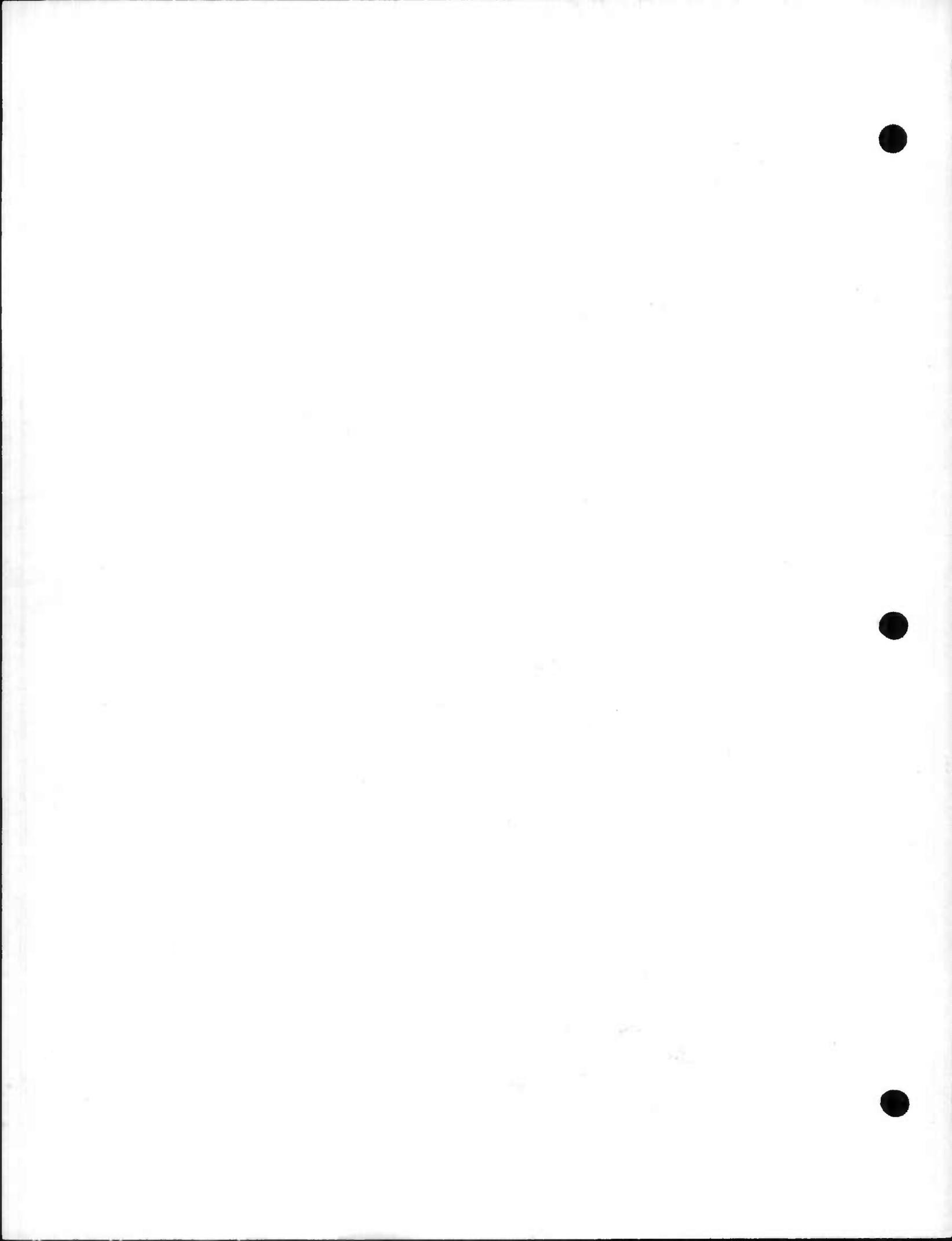
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

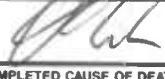
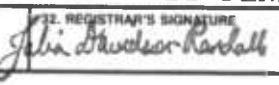
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - STATE REGISTRAR												95 19158		
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
Hilda Laura Rufino												June 5, 1995	2:40 P M	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
582-42-6900		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		70 YRS.		MONTHS		DAYS HOURS MIN.		May 10, 1925		Puerto Rico		
9a. FACILITY NAME (If not institution, give street and number)												9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH
Holy Cross Hospital												Silver Spring		Montgomery
RESIDENCE OF DECEDENT														
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
Maryland		Montgomery		Rockville										
10e. STREET AND NUMBER												10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?
4 South Duke Street												20850		USA
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES										13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Puerto Rican		14. RACE — American Indian, Black, White, etc. Specify: White
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced														
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)										16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12)		College (1-4 or 5+) 4 Homemaker										Own Home		
17. FATHER'S NAME (First, Middle, Last)												18. MOTHER'S NAME (First, Middle, Maiden Surname)		
Ignacio L. Lopez												Dolores Torres		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
Raphael Rufino		4 South Duke Street Rockville, Maryland 20850												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)										DATE	20c. LOCATION — City or Town, State	
		Parklawn Cemetery										6/8/95	Rockville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Steven J. Strand												22. NAME AND ADDRESS OF FACILITY		
												Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												days who		
a. Adult Respiratory Distress Syndrome DUE TO (OR AS A CONSEQUENCE OF):												years		
b. Bilateral Pneumonia DUE TO (OR AS A CONSEQUENCE OF):														
c. Chronic obstructive lung disease DUE TO (OR AS A CONSEQUENCE OF):														
d.														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pacemaker												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)												
		HOSPITAL:		OTHER: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide														
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER Ernest S. Oser, M.D.		29c. LICENSE NUMBER D 03792		29d. DATE SIGNED (Month, Day, Year) ► 6/6/95										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
Irnest S. Oser, M.D.		10301 Georgia Avenue Silver Spring, Maryland 20902												
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE John Shulman, Registrar												



FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) DAVID B. RABON JR.						2. DATE OF DEATH MONTH JUNE DAY 02 YEAR 1995	3. TIME OF DEATH 1:05A M	
4. SOCIAL SECURITY NUMBER 225-43-8448		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 23 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) OCT. 16, 1971		8. BIRTHPLACE (State or Foreign Country) GUAM
9a. FACILITY NAME (If not institution, give street and number) COLDSPRING AND THE ALAMEDA						9b. CITY, TOWN OR LOCATION OF DEATH BALTO CITY.		9c. COUNTY OF DEATH BALTIMORE
10e. STATE MD.		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 411 RAINDROP CT. #J						10f. ZIP CODE 21061	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES ACTIVE DUTY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SOLDIER		16b. KIND OF BUSINESS/INDUSTRY U.S. ARMY				
17. FATHER'S NAME (First, Middle, Last) DAVID RABON SR.						18. MOTHER'S NAME (First, Middle, Maiden Surname) BARBARA BLACKMON		
19e. INFORMANT'S NAME (Type/Print) DAVID RABON SR.						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) HHT 6/6 CAV, CMR 416 BOX 515, APO AE 09140		
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) VETERANS CEMETERY			DATE 6/10	20c. LOCATION — City or Town, State GUAM	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. <i>Multiple Injuries</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) INTERSECTION						
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6-2-95		28b. TIME OF INJURY M 0058	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED Driver - motorcycle - firetruck collision		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office street				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Baltimore ColdSpring Lane - The Alameda		
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) JUNE 02, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 PENN STREET, BALTIMORE, MARYLAND 21201.								
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 						

1. $\alpha = \beta$ \rightarrow $\alpha = \beta$

2. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

3. $\alpha = \beta$ \rightarrow $\alpha = \beta$

4. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

5. $\alpha = \beta$ \rightarrow $\alpha = \beta$

6. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

7. $\alpha = \beta$ \rightarrow $\alpha = \beta$

8. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

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10. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

11. $\alpha = \beta$ \rightarrow $\alpha = \beta$

12. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

13. $\alpha = \beta$ \rightarrow $\alpha = \beta$

14. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

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18. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

19. $\alpha = \beta$ \rightarrow $\alpha = \beta$

20. $\alpha \neq \beta$ \rightarrow $\alpha \neq \beta$

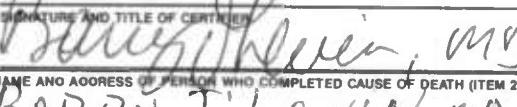
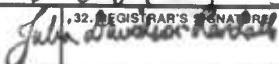
DIVISION OF VITAL RECORDS, P.O. BOX 68760

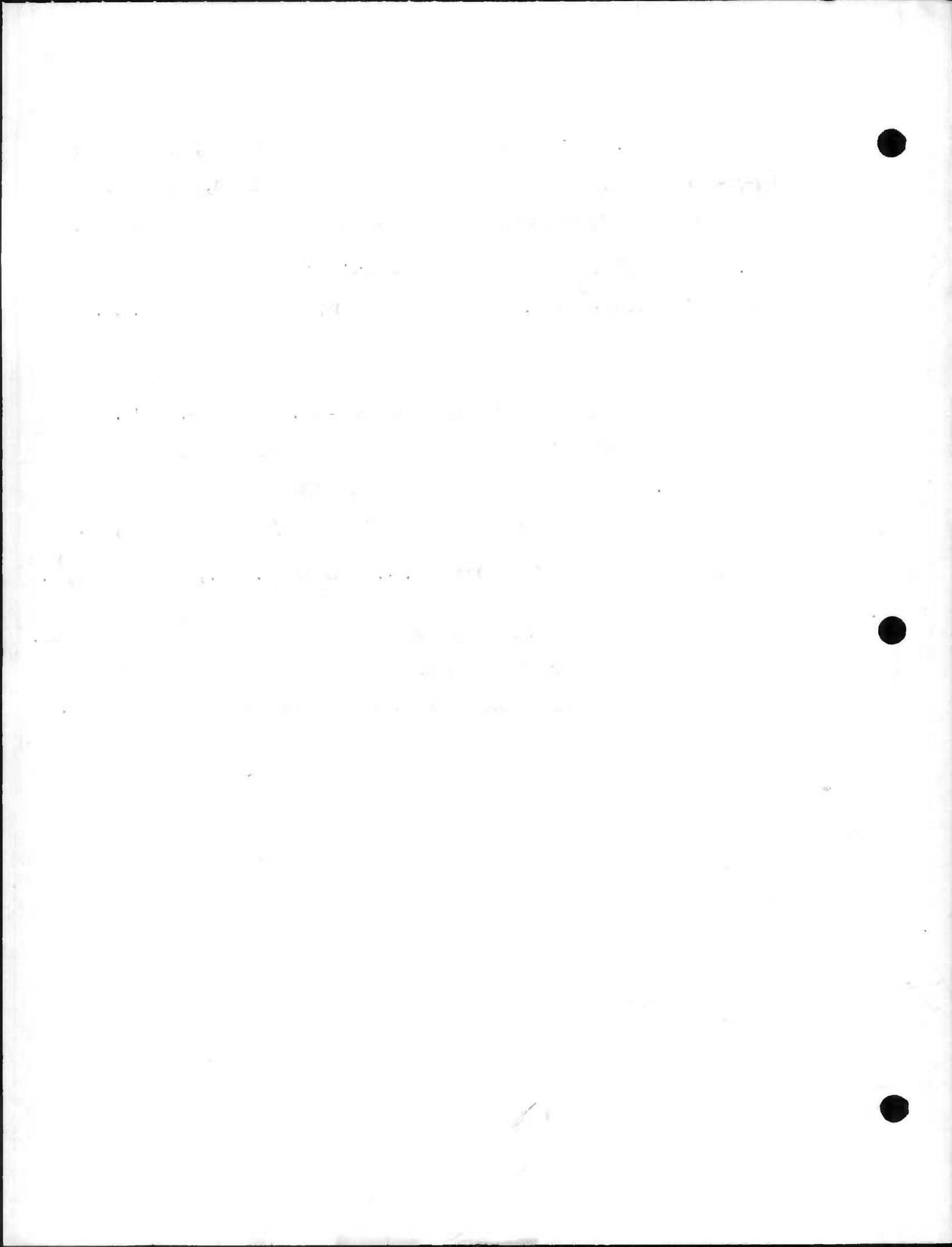
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH	3. TIME OF DEATH		
THOMAS P. REUTERSHAN										MONTH JUNE	DAY 1, 1995	YEAR 11:19 P.M.	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH	8. BIRTHPLACE (State or Foreign Country)		
067-34-8406		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	52 YRS.	MONTHS	DAYS	HOURS	MIN.			Month, Day, Year APRIL 20, 1943	NEW YORK		
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH			
SHADY GROVE ADVENTIST HOSPITAL										ROCKVILLE			
RESIDENCE OF DECEDENT										9c. COUNTY OF DEATH			
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?			
MD.	MONTGOMERY			NORTH POTOMAC						1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
15116 FALCONBRIDGE TERR.				20878				U.S.A.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+) 5+				EXECUTIVE DIRECTOR-RET.				FED. GOV'T.			
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)								
MAX PAUL REUTERSHAN					RUTH HURLEY								
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
PATRICIA O. REUTERSHAN		SAME AS ITEM #10											
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY				DATE		20c. LOCATION — City or Town, State					
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						6/4		RIVERDALE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY								20910			
		W. W. CHAMBERS CO. INC., SILVER SPRING, MD.											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												15 MIN.	
a. VENTRICULAR ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF):												4 WEEKS	
b. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):												UNK.	
c. MULTIPLE GIANT BULBOUS DISEASE LUNG BILATERAL DUE TO (OR AS A CONSEQUENCE OF):													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)				OTHER: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 20562				29d. DATE SIGNED (Month, Day, Year) ► June 2, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BARRY J. LEVIN, MD 10215 Fernmead Rd Bethesda, MD													
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE 											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

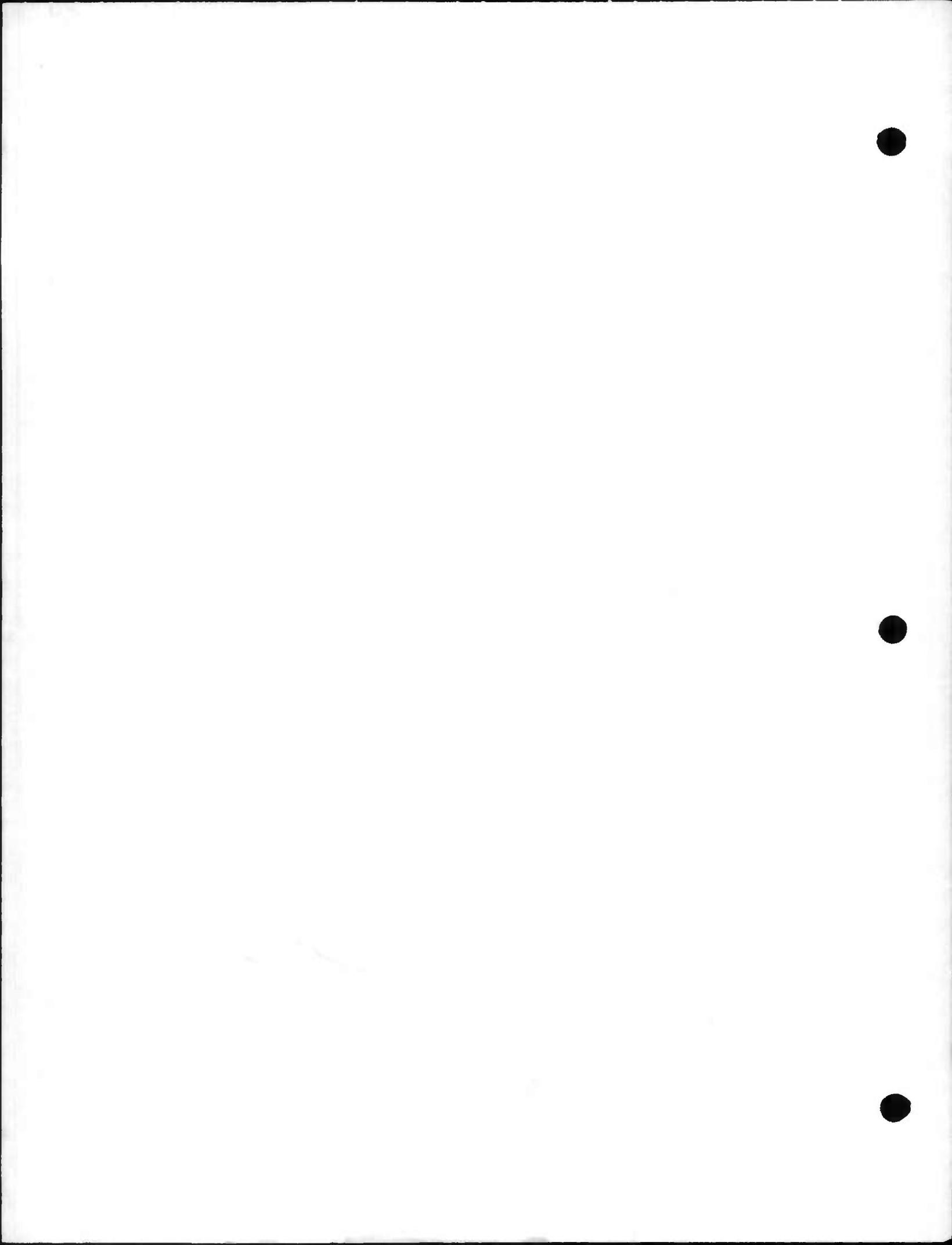
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19161

1. DECEDENT'S NAME (First, Middle, Last)		JAMES RODGERS II		2. DATE OF DEATH			3. TIME OF DEATH
EDGAR				MONTH	DAY	YEAR	~ 4:00 A.M.
220-38-3222		S. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 52 YRS.	IF UNDER 1 YEAR	IF UNDER 24 HRS.		
				MONTHS	DAYS	HOURS	MIN.
9a. FACILITY NAME (If not institution, give street and number)		207 Lakeside Drive, T-2		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
				Greenbelt		PRINCE GEORGE'S	
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Greenbelt		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 207 Lakeside Drive, T-2		10f. ZIP CODE 20770		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam Era	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)	College (1-4 or 5+) 4	16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Juvenile Probation Officer		16b. KIND OF BUSINESS/INDUSTRY Juvenile Services			
17. FATHER'S NAME (First, Middle, Last) Edgar James Rodgers		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth French					
19a. INFORMANT'S NAME (Type/Print) John F. Rodgers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2716 Cathedral Avenue, NW #10, Washington, DC 20008					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 6/2	20c. LOCATION — City or Town, State Beltsville, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Debra L. Rapp		22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Avenue, Silver Spring, MD 20910					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. ISCHEMIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. MORBID OBESITY DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>							
Approximate Interval Between Onset and Death minutes							
UNK yrs.							
UNK yrs.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND	28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER J. Berger MD		29c. LICENSE NUMBER 025925		29d. DATE SIGNED (Month, Day, Year) ► May 29, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Berger MD #205, 7720 Wisconsin Ave, Bethesda MD 20814							
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE John D. Berger, M.D.					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

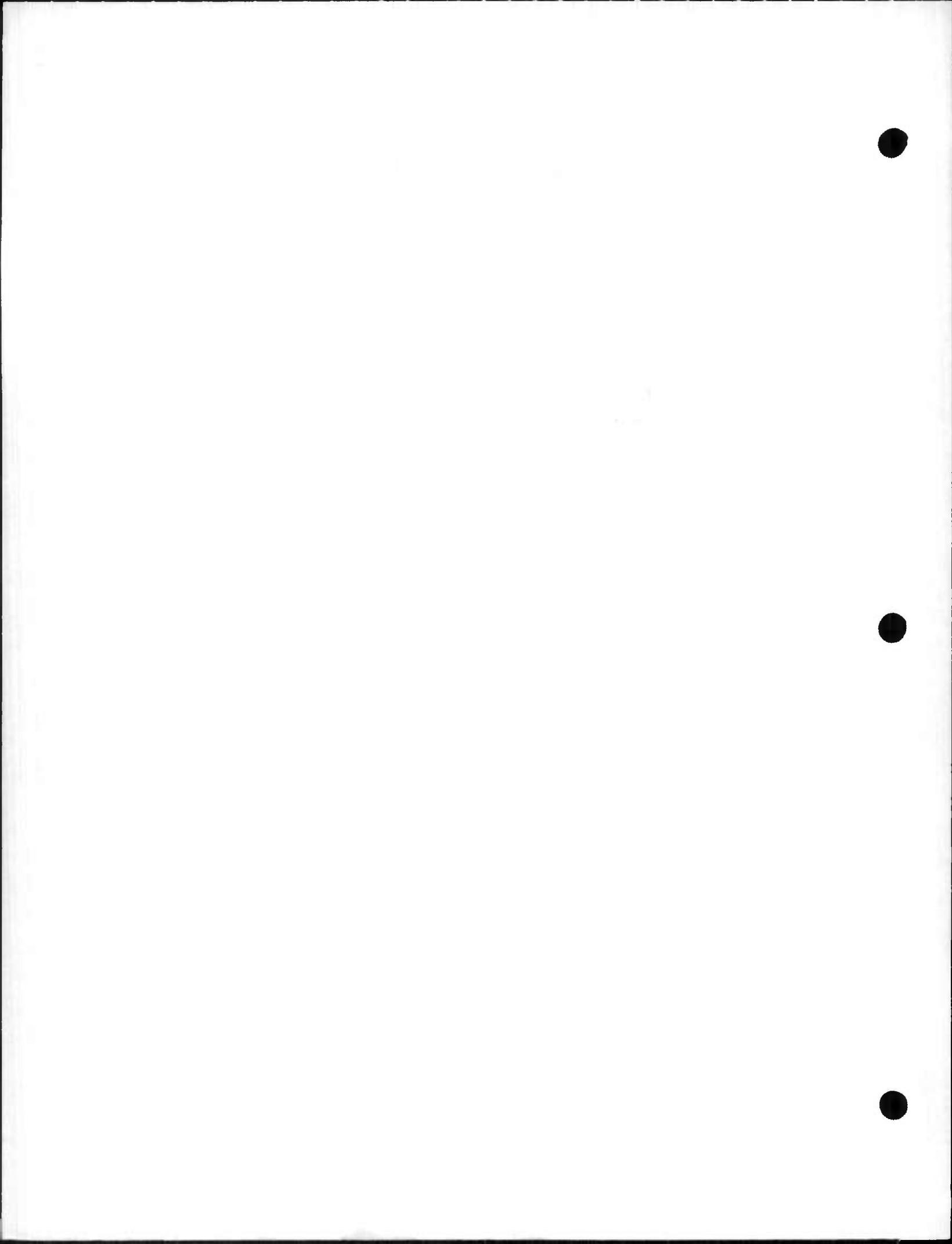
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 5, 1995								3. TIME OF DEATH 5:50 a.m.		
1. DECEDENT'S NAME (First, Middle, Last) Nellie Anita Rupp										7. DATE OF BIRTH (Month, Day, Year) May 5, 1903	8. BIRTHPLACE (State or Foreign Country) Maryland	
4. SOCIAL SECURITY NUMBER 220-24-1874		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9a. FACILITY NAME (If not institution, give street and number) Shady Grove Adventist Nursing Center			9b. CITY, TOWN OR LOCATION OF DEATH Rockville	9c. COUNTY OF DEATH Montgomery
RESIDENCE OF DECEDENT										10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STATE Virginia	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Alexandria								10f. ZIP CODE 22301	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Teacher				16b. KIND OF BUSINESS/INDUSTRY Elementary School						
17. FATHER'S NAME (First, Middle, Last) Frank Morton Rupp										18. MOTHER'S NAME (First, Middle, Maiden Surname) Toy Pauline Shirley		
19a. INFORMANT'S NAME (Type/Print) Nancy N. Brown										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 E. Cliff Street, Alexandria, VA 22301		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery 6/7/95				DATE	20c. LOCATION — City or Town, State Baltimore, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael D. Culver		22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home				10 East Deer Park Drive Gaithersburg, MD 20877						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → DEMENTIA (SENILE)										Approximate Interval Between Onset and Death 4 YEARS.		
b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {												
c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>										25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 36552										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Pankaj Talwar 50 W. Edmonston Drive #401, Rockville, MD 20852		29d. DATE SIGNED (Month, Day, Year) ► June 5, 1995										
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE J. D. Culver, R.D.										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

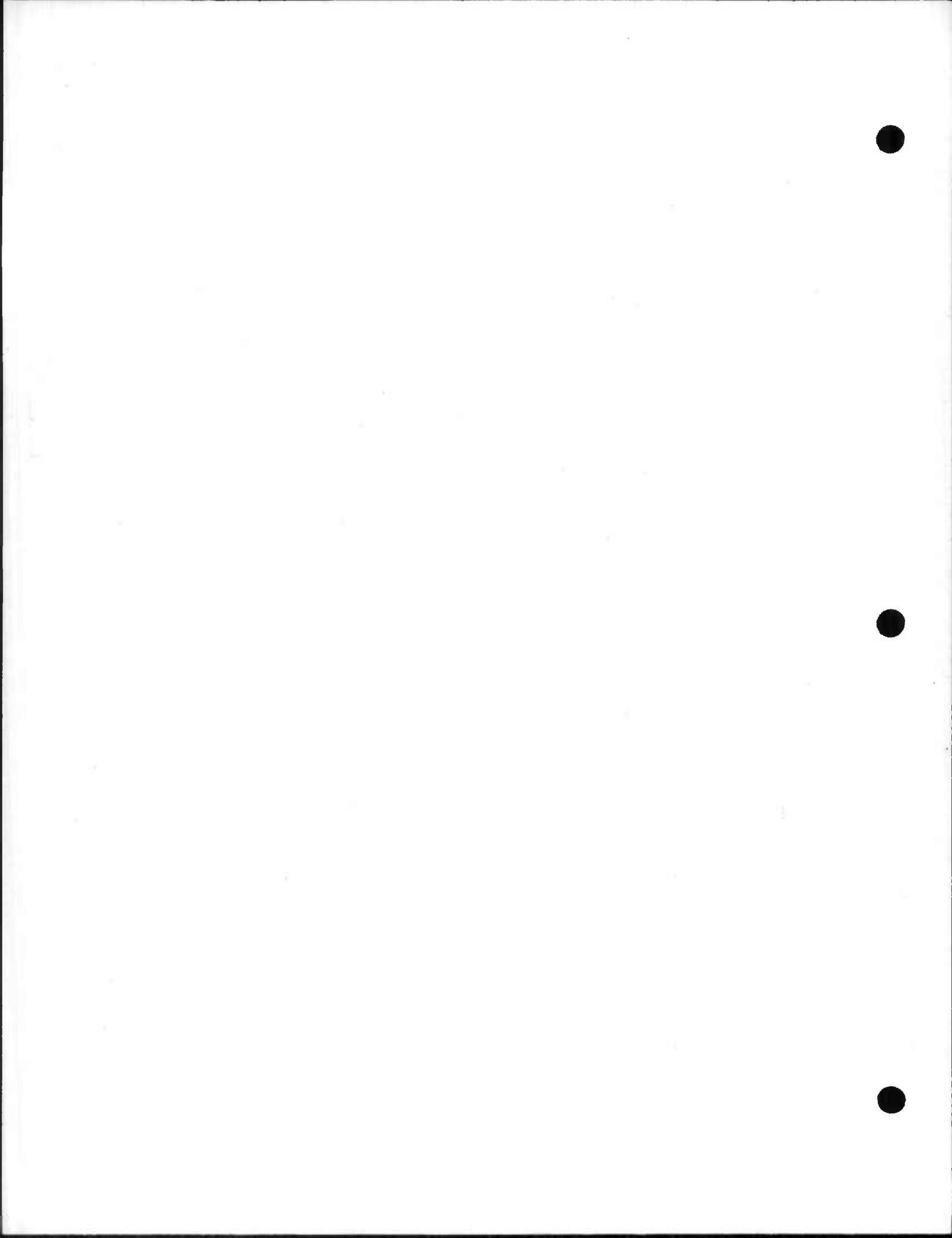
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR <i>JUN 10 1995</i>								3. TIME OF DEATH 5:50 P M	
1. DECEDENT'S NAME (First, Middle, Last) <i>Eula Fulford Ruff</i>											
4. SOCIAL SECURITY NUMBER <i>214-24-1830</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>82</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month Day, Year) <i>Feb 15, 1913</i>		8. BIRTHPLACE (State or Foreign Country) <i>MD</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Fallston Gen. Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Fallston</i>								9c. COUNTY OF DEATH <i>HARFORD</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>HARFORD</i>		10c. CITY, TOWN OR LOCATION <i>BELAIR</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>213 FRANKLIN ST.</i>						10f. ZIP CODE <i>21014</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <i>John F. Ruff</i>		18. MOTHER'S NAME (First, Middle) Maiden Surname <i>MARY H. Lewis</i>									
19a. INFORMANT'S NAME (Type/Print) <i>FRANCES McCRAE</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>213 FRANKLIN ST Belair MD</i>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) <i>Belair Memorial 6-17</i>				DATE		20c. LOCATION — City or Town, State <i>Belair MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <i>BEARD Funeral Home 406 MD</i>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): <i>b. MASSIVE Intracerebral Hematoma</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. d.</i>										1 week	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Panayiotis L. Sitanas</i>		29c. LICENSE NUMBER <i>D14121</i>				29d. DATE SIGNED (Month, Day, Year) <i>JUNE 12, 1995</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Panayiotis L. Sitanas, 1814 Belair Rd. Fallston Md 21047</i>											
31. DATE FILED (Month, Day, Year) <i>JUN 13 1995</i>		32. REGISTRAR'S SIGNATURE <i>Sabin Davidson Randall</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

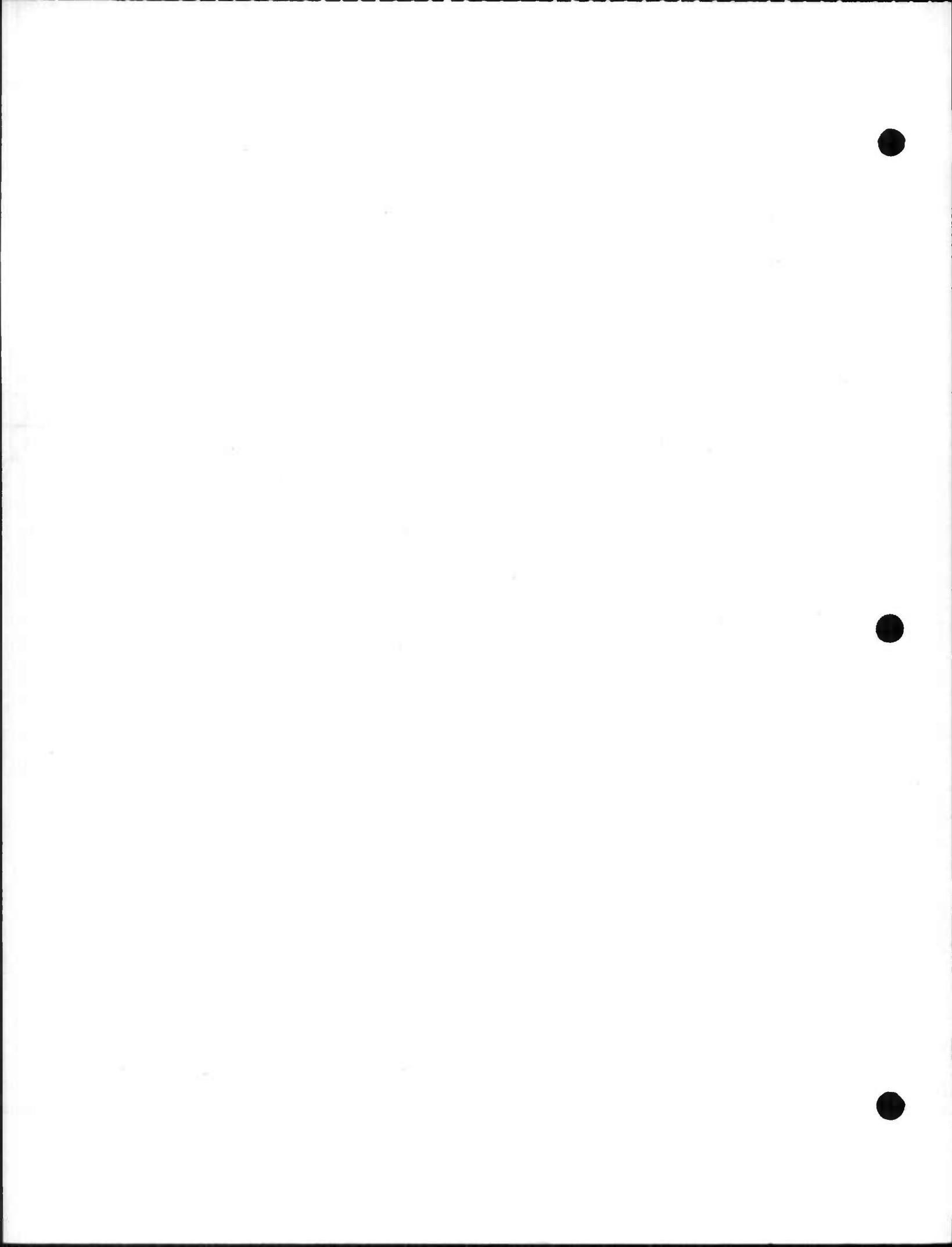
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. 95 19164		
1. DECEDENT'S NAME (First, Middle, Last) GUY SCOTT ROBEY SR							2. DATE OF DEATH MONTH JUNE DAY 3, 1995 YEAR		3. TIME OF DEATH 2:40 A.M.		
4. SOCIAL SECURITY NUMBER 214 07 6215		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 78 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month Day Year) Oct 2, 1916		8. BIRTNPLACE (State or Foreign Country) WV	
9a. FACILITY NAME (If not institution, give street and number) MEMORIAL HOSPITAL							9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND		9c. COUNTY OF DEATH ALLEGANY		
RESIDENCE OF DECEDENT											
10a. STATE MD	10b. COUNTY Allegany		10c. CITY, TOWN OR LOCATION Cumberland			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 355 Bedford Street				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Custodian			16b. KIND OF BUSINESS/INDUSTRY County School Board						
17. FATHER'S NAME (First, Middle, Last) William Robey							16. MOTHER'S NAME (First, Middle, Maiden Surname) Anna C. (nm)				
18a. INFORMANT'S NAME (Type/Print) Barbara Twigg				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 355 Bedford Street; Cumberland, MD 21502							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) MC. Tabor Cemetery				20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Cemetery or other place) MC. Tabor Cemetery		DATE 06/05		20c. LOCATION — City or Town, State Oldtown, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
s. Acute Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
Approximate Interval Between Onset and Death 1 hour											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
1 <input checked="" type="checkbox"/> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> 謀殺 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)											
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D33280		29d. DATE SIGNED (Month, Day, Year) June 3, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. SUNIL GUPTA/JOHNSON HEIGHTS MEDICAL BLDG/SUITE 101/CUMBERLAND, MD 21502											
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

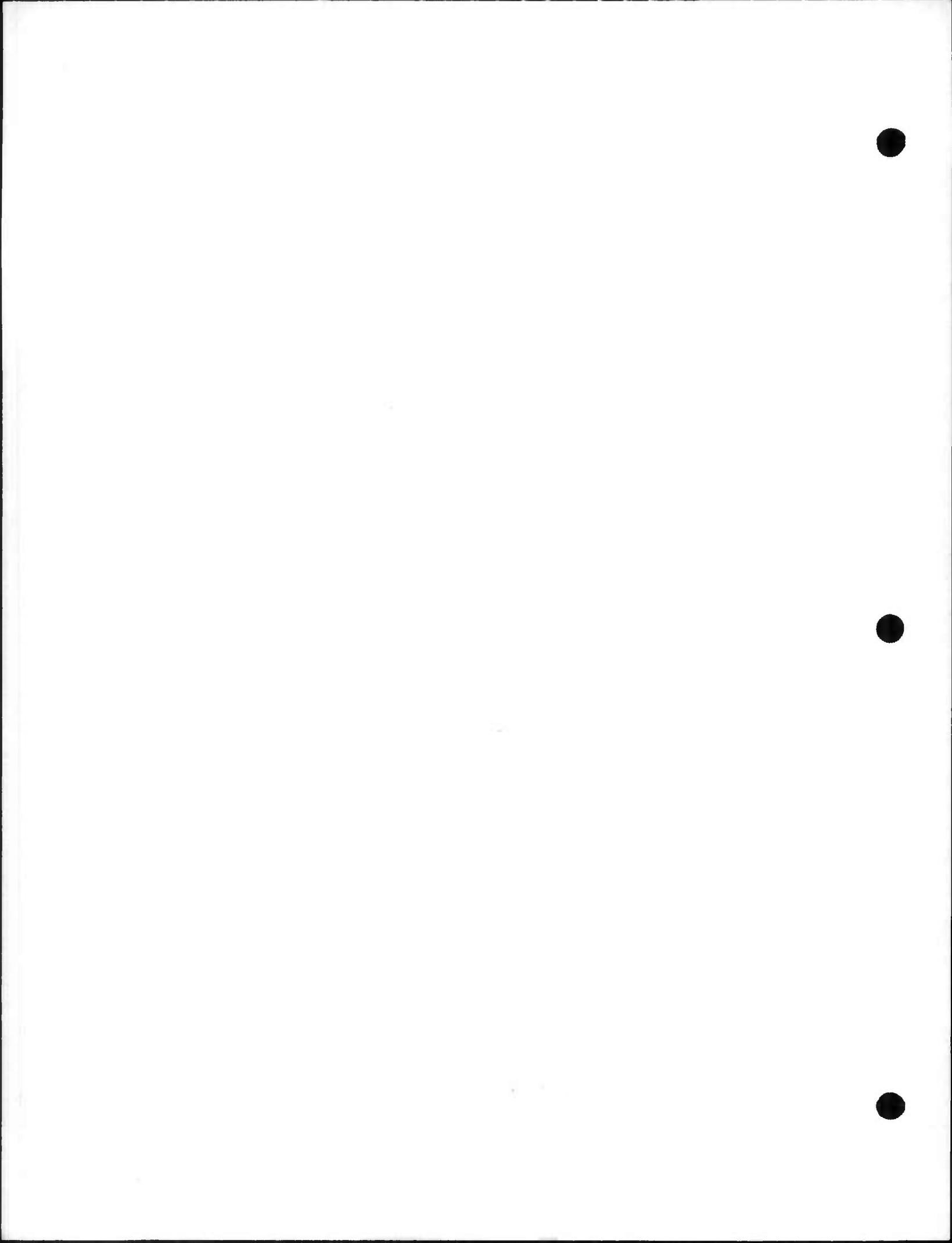
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		Stephen M. Ryan						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		B. BIRTHPLACE (State or Foreign Country)	
212 62 2455		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	42 YRS.	MONTHS	DATE	HOURS	MIN.	May 6, 1953		Washington D.C.	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH			
12500 Scarlet Lane		Bowie						Prince George's			
RESIDENCE OF DECEDEDENT											
10e. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?		
Maryland	Prince George's		Bowie						1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?			
12500 Scarlet Lane		20715						United States			
11. MARITAL STATUS		12. WAS DECEDEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					No			No			
15. DECEDEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12) 0		College (1-4 or 5+) Piece Worker			Ardmore Enterprises						
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)					
John M. Ryan						Ann M. Cap					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Kathleen A. Wolf				15101 Peach Orchard Rd. Silver Spring Md. 20905							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE	20c. LOCATION — City or Town, State			
				Mt. Olivet Cemetery 6/2/95				Washington D.C.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Evans Pres.</i>				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Down's syndrome</i>											
Approximate interval Between Onset and Death 42 yrs											
a. _____				DUE TO (OR AS A CONSEQUENCE OF): <i>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</i>							
b. _____				DUE TO (OR AS A CONSEQUENCE OF):							
c. _____				DUE TO (OR AS A CONSEQUENCE OF):							
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hepatitis B carrier</i>											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George C. Hajjar, Jr. M.D.</i>						29c. LICENSE NUMBER 039550		29d. DATE SIGNED (Month, Day, Year) ► 6-1-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George C. Hajjar, Jr. M.D. 4850 Forbes Blvd. Lanham, Md 20706</i>											
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE <i>Jeha Dawson Redell</i>									



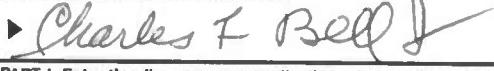
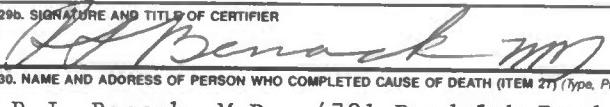
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

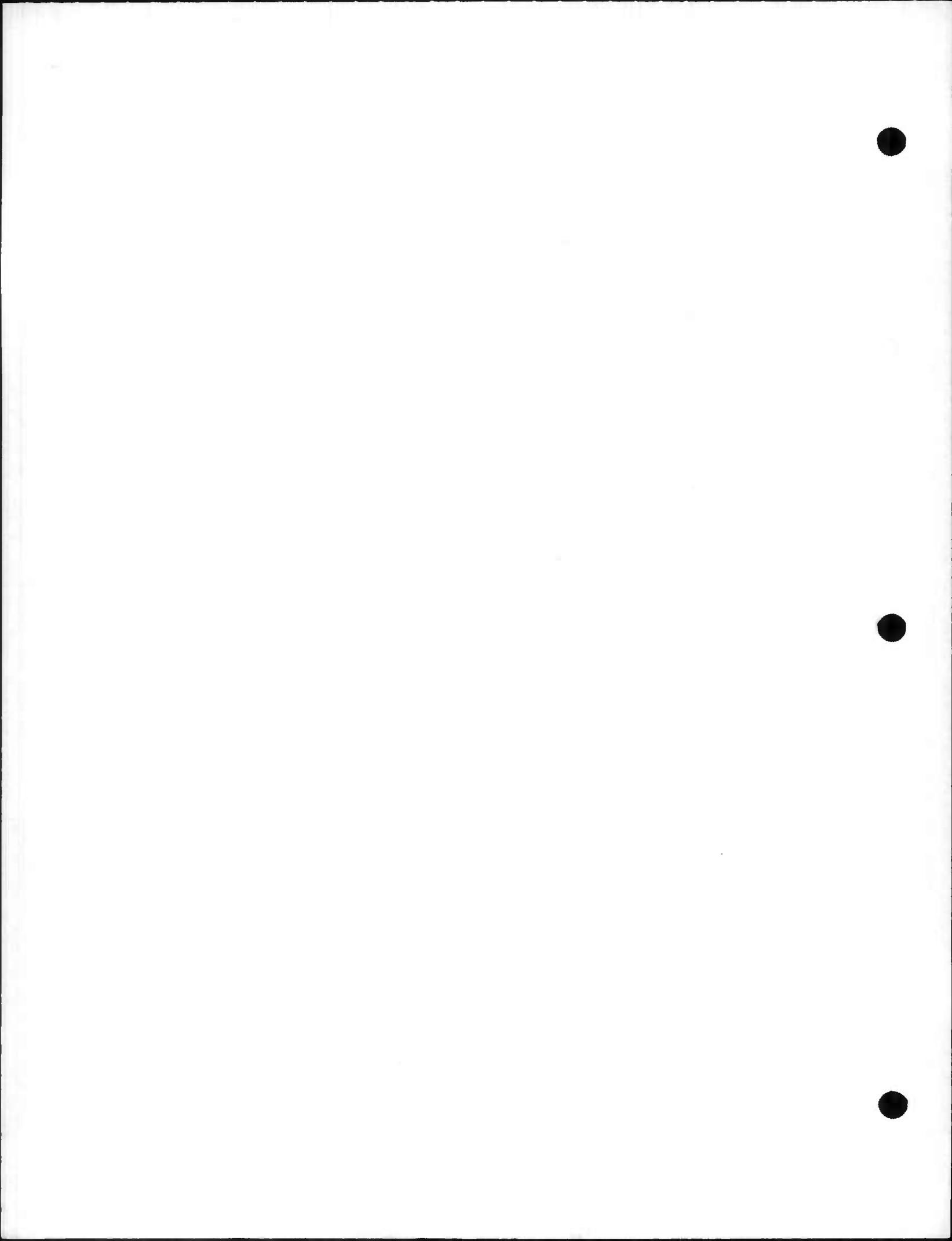
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) MYRTLE M. RANSOM										2. DATE OF DEATH MONTH DAY YEAR May 27, 1995	3. TIME OF DEATH 10:30 A M
4. SOCIAL SECURITY NUMBER 468-22-9977		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 23, 1920	
9a. FACILITY NAME (If not institution, give street and number) Medlantic Nursing Home										9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	
9c. COUNTY OF DEATH Montgomery										8. BIRTHPLACE (State or Foreign Country) Minnesota	
RESIDENCE OF DECEDENT										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Boonsboro						10f. ZIP CODE 21713	
10e. STREET AND NUMBER 21701 Old Boonsboro Mt. Road										10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Malker Fangstrom										18. MOTHER'S NAME (First, Middle, Maiden Surname) Mable Topping	
19a. INFORMANT'S NAME (Type/Print) Fred L. Ransom, Jr.					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16009 Wallingford Road, Silver Spring, Maryland						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		DATE 05/31/95		20c. LOCATION — City or Town, State Brentwood, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Obstructive Pulmonary Disease										Approximate Interval Between Onset and Death Years	
b. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Vascular Accident										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER D557					29d. DATE SIGNED (Month, Day, Year) 06/01/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R.J. Benack, M.D. 4701 Randolph Road, Rockville, Maryland 20852											
31. DATE FILED (Month, Day, Year) JUN 02 1995		32. REGISTRAR'S SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

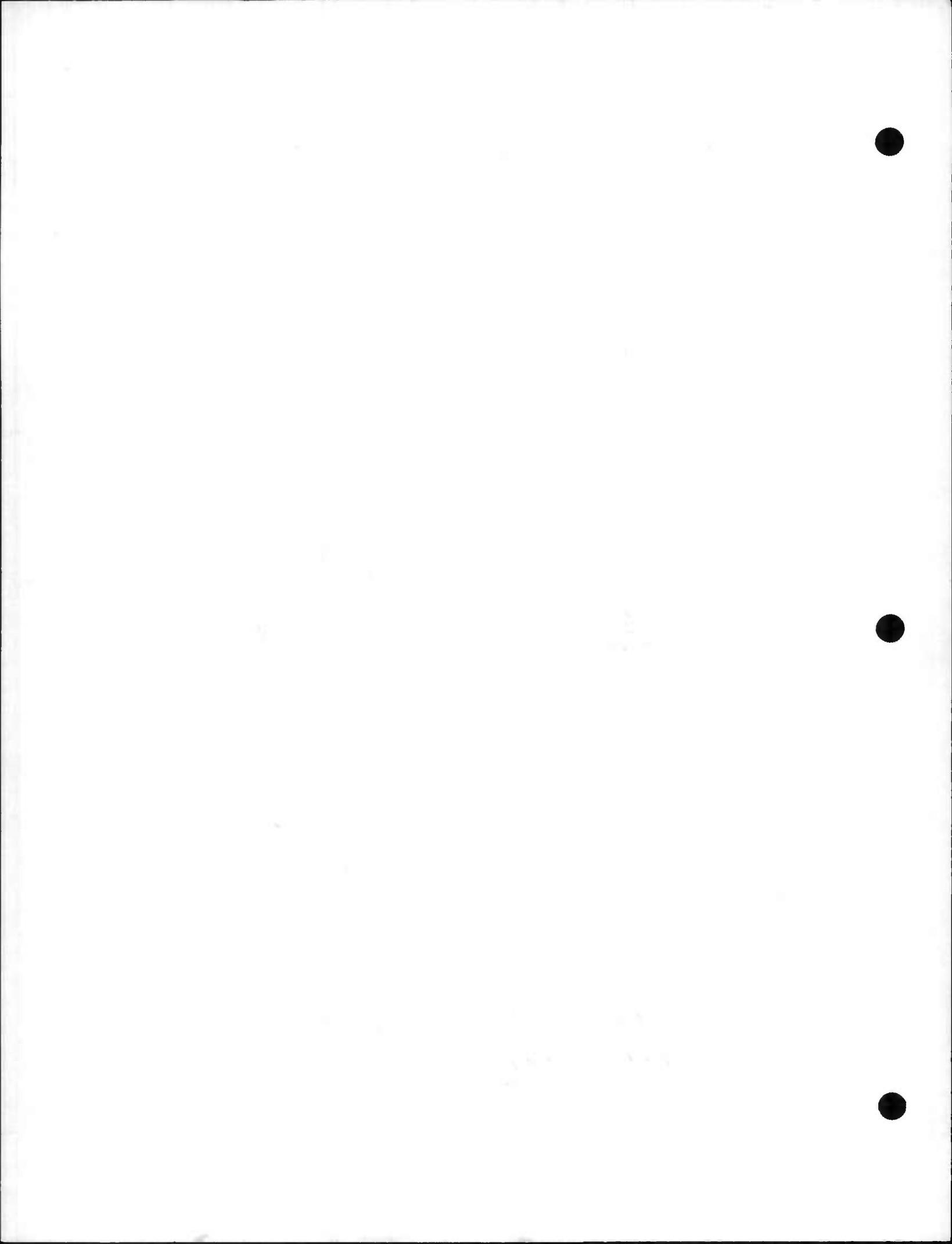
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR										95 19167	
1. DECEDENT'S NAME (First, Middle, Last)		<i>Albert Riley</i>				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH H 9:30 A M			
4. SOCIAL SECURITY NUMBER 578 12 9660		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 12, 1912		8. BIRTHPLACE (State or Foreign Country) Denmark, S.C.	
9a. FACILITY NAME (If not institution, give street and number) 505 Suffolk Avenue #319		9b. CITY, TOWN OR LOCATION OF DEATH Capitol Heights								9c. COUNTY OF DEATH PG	
10a. STATE Maryland		10b. COUNTY Prince George		10c. CITY, TOWN OR LOCATION Capitol Heights						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 505 Suffolk Avenue #319						10f. ZIP CODE 20743		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: NO				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Plasterer				16b. KIND OF BUSINESS/INDUSTRY Private					
17. FATHER'S NAME (First, Middle, Last) Oscar Riley		18. MOTHER'S NAME (First, Middle, Maiden Surname) unknown									
19a. INFORMANT'S NAME (Type/Print) Margaret Riley		19d. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Suffolk Avenue #319 20743 Capitol Heights, Maryland									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harmony Memorial Park				DATE 6/9/95		20c. LOCATION — City or Town, State Landover, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jahn T. Stewart III</i>		22. NAME AND ADDRESS OF FACILITY Stewart Funeral Home 4001 Benning Road, N.E., Washington, D.C.									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. _____ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): d. _____ DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		26a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusta P. Rodriguez MD</i>		29c. LICENSE NUMBER D 212 30				29d. DATE SIGNED (Month, Day, Year) June 5, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusta P. Rodriguez MD, 5009 Rayburn Ct. Op-Spr Md 20748</i>											
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE <i>John Shuler</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

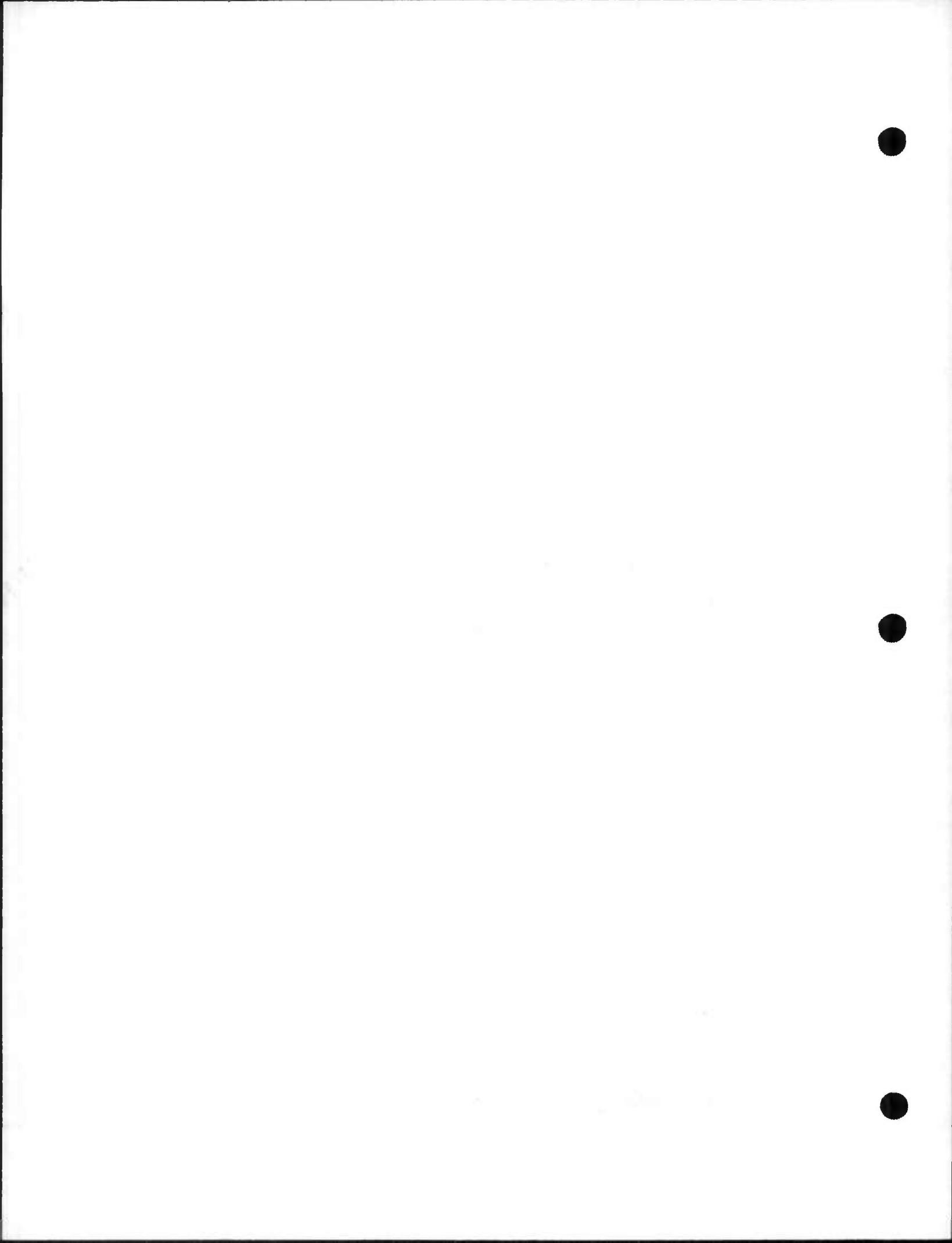
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19168

1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH 6:48 pm M		
Lawrence Grayson REED				June 7, 1995						
4. SOCIAL SECURITY NUMBER 213-24-8761		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 5, 1929		
8a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick				9c. COUNTY OF DEATH Frederick		8b. BIRTHPLACE (State or Foreign Country) Maryland		
RESIDENCE OF DECEASED										
10e. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Thurmont				10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO				
10e. STREET AND NUMBER 13532 Catoctin Furnace Road			10f. ZIP CODE 21788			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Heavy Equipment Operator			16b. KIND OF BUSINESS/INDUSTRY Genstar Construction					
17. FATHER'S NAME (First, Middle, Last) Marshall Walker Reed				18. MOTHER'S NAME (First, Middle, Maiden Surname) Leotto Mae Wollard						
19a. INFORMANT'S NAME (Type/Print) Lawrence Wayne Reed				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7459 Franklinville Road, Thurmont, MD 21788						
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Blue Ridge Cemetery			DATE 6/10	20c. LOCATION — City or Town, State Thurmont, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										
22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 615 EAST MAIN STREET THURMONT, MD 21788										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease										
Approximate Interval Between Onset and Death Years										
b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
c. DUE TO (OR AS A CONSEQUENCE OF):										
d. DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO □ UNCERTAIN □										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 X DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)								
27. MANNER OF DEATH 1 X Natural 5 □ Pending investigation 2 □ Accident 3 □ Suicide 4 □ Homicide 6 □ Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 □ YES 2 □ NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER D09867			29d. DATE SIGNED (Month, Day, Year) ► June 8, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 21) (Type, Print) Robert R.R. Roberts, M.D., 15 West Seventh Street, Frederick, Maryland 21701										
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

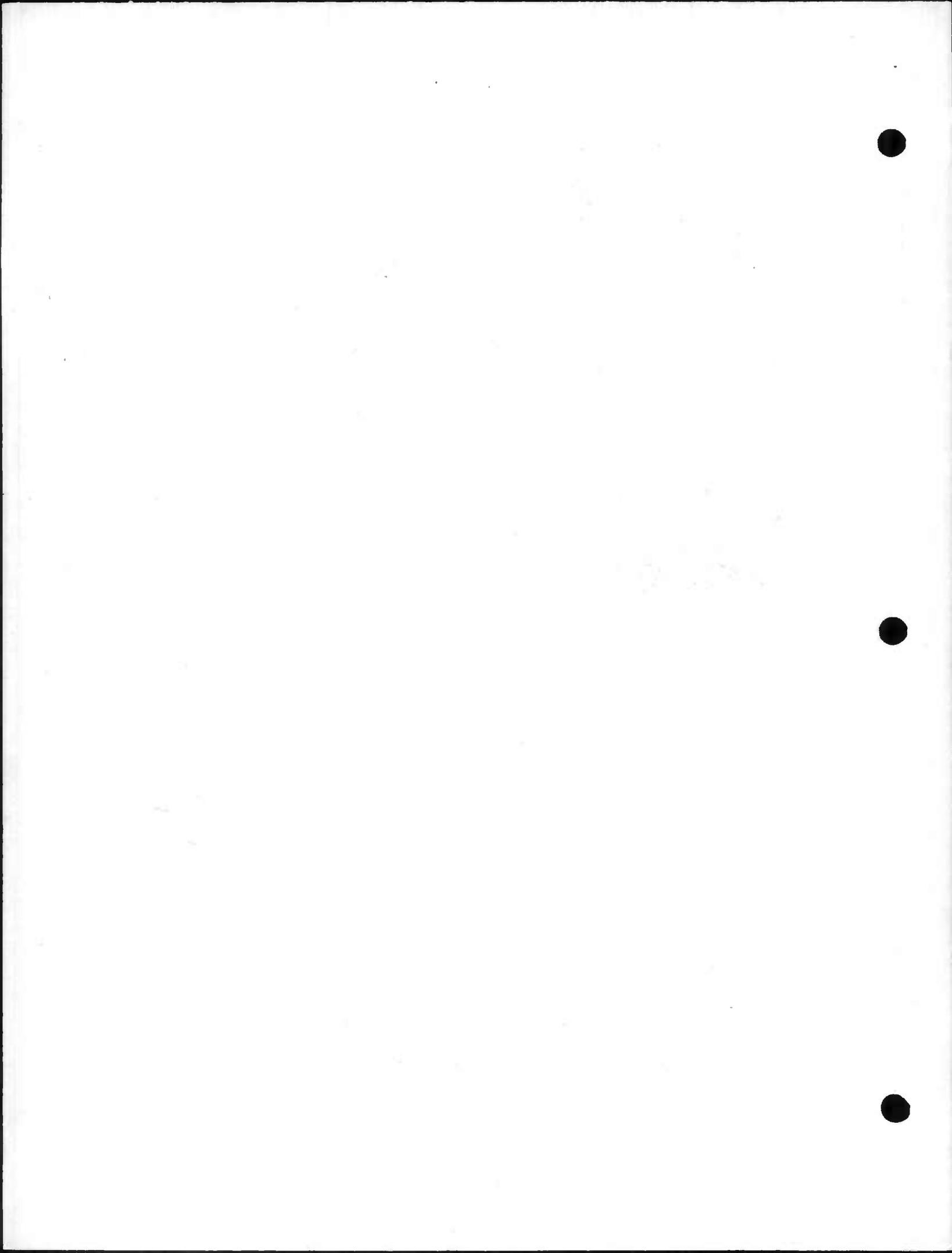
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)		VOULA A. ROIS								2. DATE OF DEATH MONTH DAY YEAR			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		3. TIME OF DEATH			
215-60-2623		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		90 YRS.		MONTHS		DAYS HOURS MIN.		7:55 AM			
9a. FACILITY NAME (If not institution, give street and number)		BERLIN NURSING HOME								7. DATE OF BIRTH (Month, Day, Year)			
BERLIN NURSING HOME		BERLIN								2-8-05			
9b. COUNTY OF DEATH		WORCESTER								8. BIRTHPLACE (State or Foreign Country)			
WORCESTER										GREECE			
RESIDENCE OF DECEDENT													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
MD.		WORCESTER		OCEAN CITY									
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?			
207 143RD STREET		21842								USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 12		College (1-4 or 5+) HOMEMAKER				OWN HOME							
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)											
EVANGELOS ARNIOTIS		MARIA KOMINOS											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
MARINE CHACONAS		207 143RD ST., OCEAN CITY, MD., 21842											
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		GREEK ORTHODOX				6-15		BALTIMORE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE													
22. NAME AND ADDRESS OF FACILITY													
ULLRICH FUNERAL HOME BERLIN, MD.													
23. PAIN: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
e. <i>Ferninal pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): Sensitivity													
b. <i>Sensitivity</i> DUE TO (OR AS A CONSEQUENCE OF): Diseas cerosis													
c. <i>Diseas cerosis</i> DUE TO (OR AS A CONSEQUENCE OF): Age.													
Approximate Interval Between Onset and Death 5 days													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)								24a. WAS AN AUTOPSY PERFORMED?			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA								4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month, Day, Year)			
29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER								► 6-13-95			
		DO2026											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
Federico G. Arthes 1622A Ocean Pines Berlin MD 21811 410-641-4400													
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE											
JUN 13 1995		<i>Julieta Arthes-Randall</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

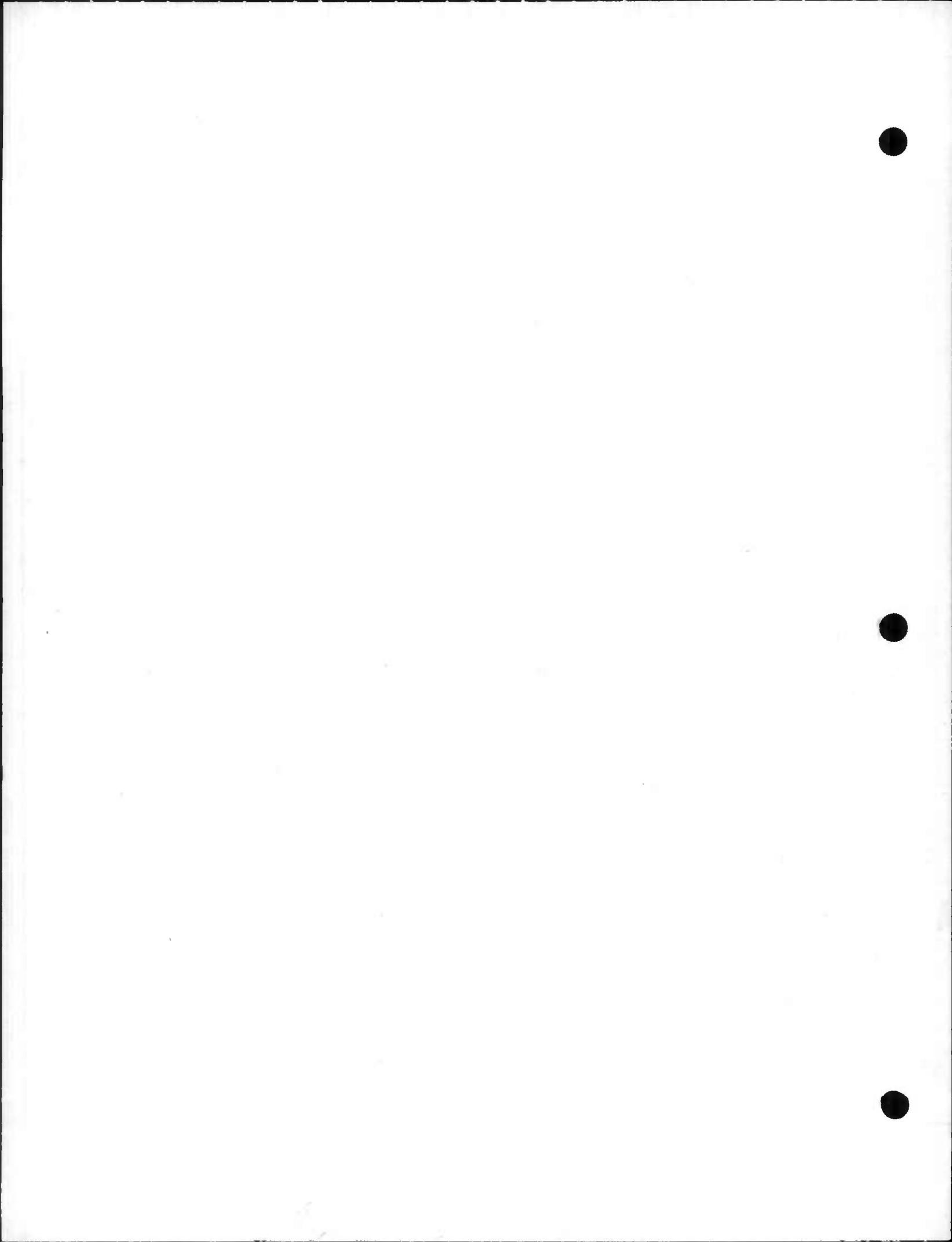
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEASED'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH JUNE DAY 6 YEAR 1995	3. TIME OF DEATH 3:15 P M		
Olive Emma Stewart														
4. SOCIAL SECURITY NUMBER 171-48-4363		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 98 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 5, 1897	8. BIRTNPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) Laurel Regional Hospital											9b. CITY, TOWN OR LOCATION OF DEATH Laurel	9c. COUNTY OF DEATH Prince Georges		
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION College Park		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO								
10e. STREET AND NUMBER 9505 52nd Avenue						10f. ZIP CODE 20740			10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2		13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify:								
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher		16b. KIND OF BUSINESS/INDUSTRY Education										
17. FATHER'S NAME (First, Middle, Last) James Beers		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Neufer												
19a. INFORMANT'S NAME (Type/Print) Mary S. Burns		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9501 52nd Ave., College Park, MD 20740		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenwood Cemetery		DATE 6/10/95		20c. LOCATION — City or Town, State Indiana, PA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 1 Day		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):														
b. Aspiration DUE TO (OR AS A CONSEQUENCE OF):														
c. Cerebro Vascular Accident DUE TO (OR AS A CONSEQUENCE OF):														
d.														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Arterial Fibrillation												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)		27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. L. Marshall</i>		29c. LICENSE NUMBER D 24721		29d. DATE SIGNED (Month, Day, Year) ► June 7, 1995								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14800 4th St., Suite 11A Laurel MD 20707												31. DATE FILED (Month, Day, Year) JUN 08 1995		
32. REGISTRAR'S SIGNATURE <i>Julie Marshall Marshall</i>												DHMH-18 Rev 1/89		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

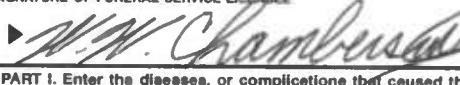
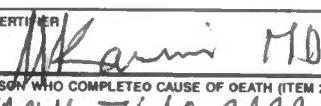
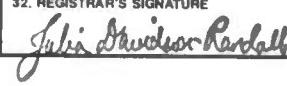
TO BE COMPLETED BY FUNERAL DIRECTOR

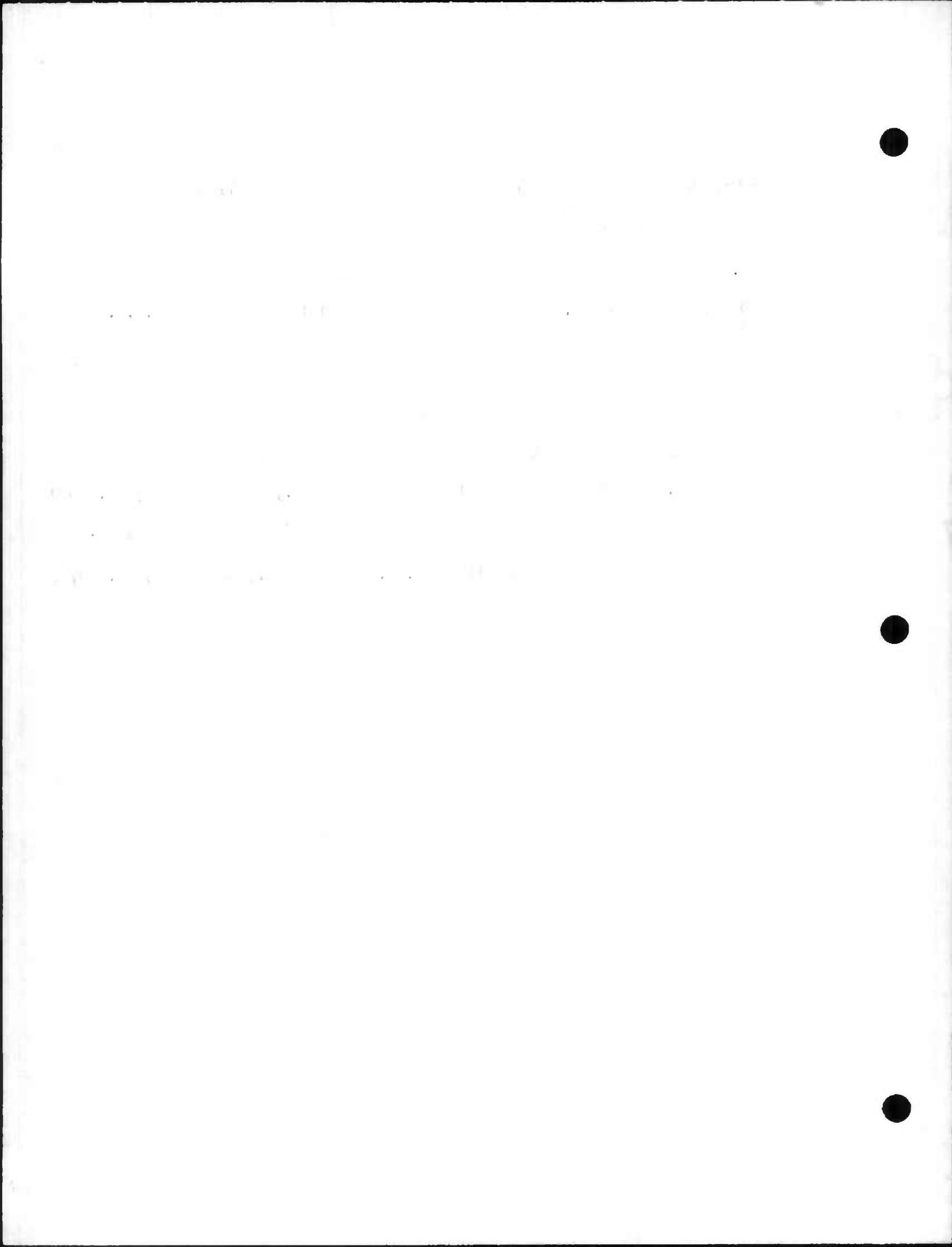
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19171

1. DECEASED'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR June 4, 1995	3. TIME OF DEATH 4:47 A. M.
Helen Higgins Shelton							
4. SOCIAL SECURITY NUMBER 154-09-5905		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) MARCH 7, 1916	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK	
9c. COUNTY OF DEATH MONTGOMERY							
10a. STATE MD.		10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION SILVER SPRING			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8401 PINEY BRANCH RD.				10f. ZIP CODE 20901		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LIBRARIAN			16b. KIND OF BUSINESS/INDUSTRY LIBRARY		
17. FATHER'S NAME (First, Middle, Last) REYBURN HIGGINS				16. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN McKEE			
19a. INFORMANT'S NAME (Type/Print) WILLIAM C. SHELTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8401 PINEY BRANCH RD., SILVER SPRING, MD. 20901			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) PARKLAWN CEMETERY			DATE 6/8	20c. LOCATION — City or Town, State ROCKVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  W.W. Chambers M00091				22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the disease(s), or complication(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Sepsis</i> <small>DUE TO (OR AS A CONSEQUENCE OF)</small> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Subdiaphragmatic Abscess with</i> <small>DUE TO (OR AS A CONSEQUENCE OF)</small> <i>Complication of Bowel infarction</i> <small>DUE TO (OR AS A CONSEQUENCE OF)</small> Several days Several days Several days							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D-18895		29d. DATE SIGNED (Month, Day, Year) ► 6-05-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MOBARAK KARIM, 7610 CARROLL AVE, TAKOMA PARK, MD							
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 					



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

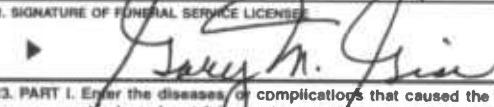
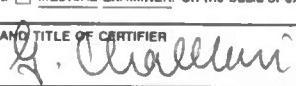
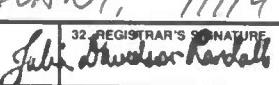
TO BE COMPLETED BY FUNERAL DIRECTOR

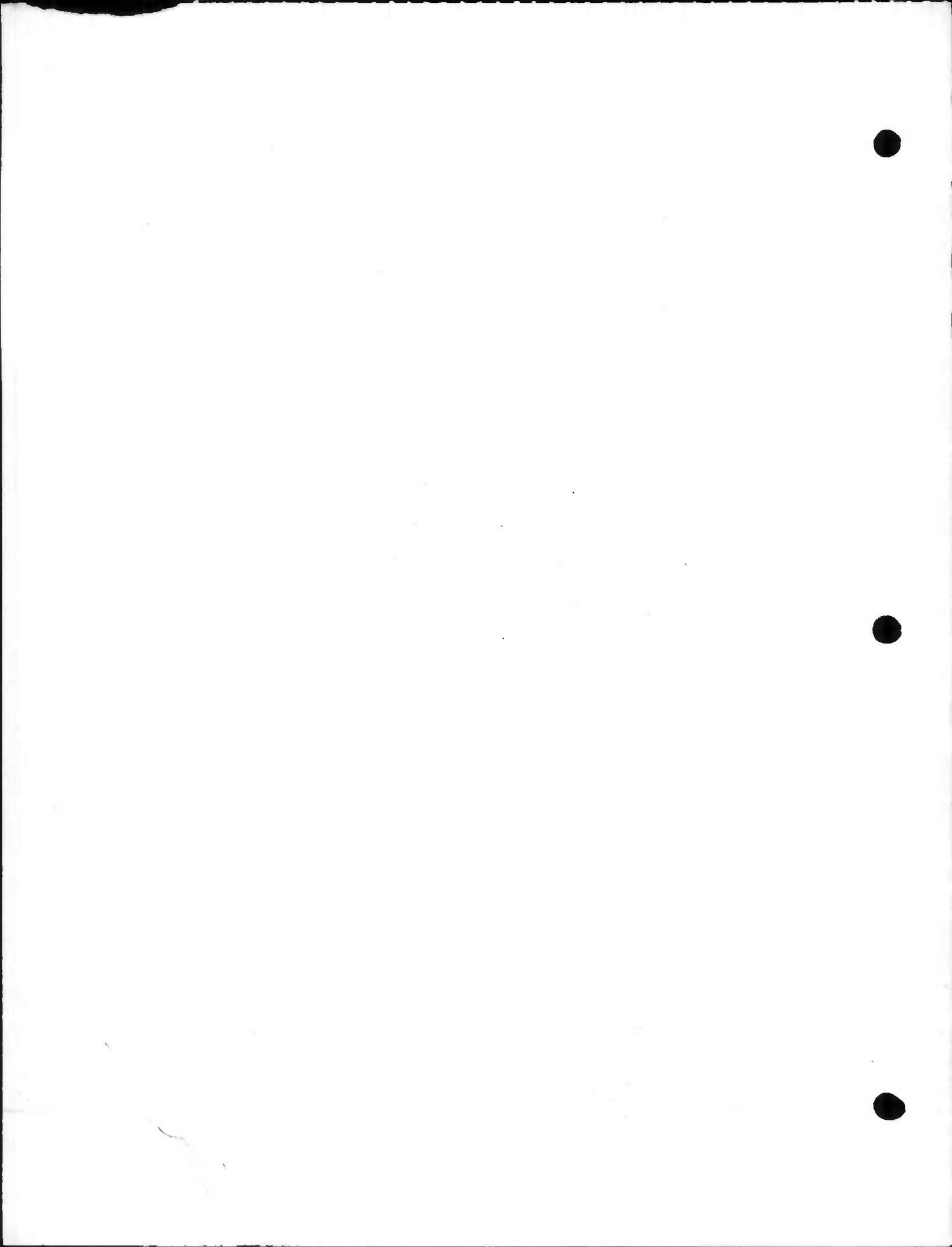
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19172

1. DECEASED'S NAME (First, Middle, Last) HENRIETTA SHERMAN				2. DATE OF DEATH MONTH DAY YEAR JUNE 3, 1995		3. TIME OF DEATH 8:00 AM M			
4. SOCIAL SECURITY NUMBER 217-34-0392		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 98 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) MARCH 5, 1897	8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA		
9a. FACILITY NAME (If not institution, give street and number) HEBREW HOME OF GREATER WASHINGTON				9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY			
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5108 LUPINE COURT				10f. ZIP CODE 20853		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) OWNER		16b. KIND OF BUSINESS/INDUSTRY BEAUTY SALON					
17. FATHER'S NAME (First, Middle, Last) SAMUEL SHENGOLD				18. MOTHER'S NAME (First, Middle, Maiden Surname) ESTHER					
19a. INFORMANT'S NAME (Type/Print) CHERIE SIEGEL (DAUGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5108 LUPINE COURT - ROCKVILLE, MARYLAND 20853					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Facility, if applicable) KING DAVID MEMORIAL GARDEN		DATE 6/6	20c. LOCATION — City or Town, State FALLS CHURCH, VIRGINIA				
21. SIGNATURE OF FUNERAL SERVICE LICENCIATE 				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE - ROCKVILLE, MD. 20852					
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → PNEUMONIA									
Approximate Interval Between Onset and Death 2 days									
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D42518		29d. DATE SIGNED (Month, Day, Year) JUNO 3, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gill CHAITANJI, 11119 Rockville Pike, Rockville, MD									
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE 							



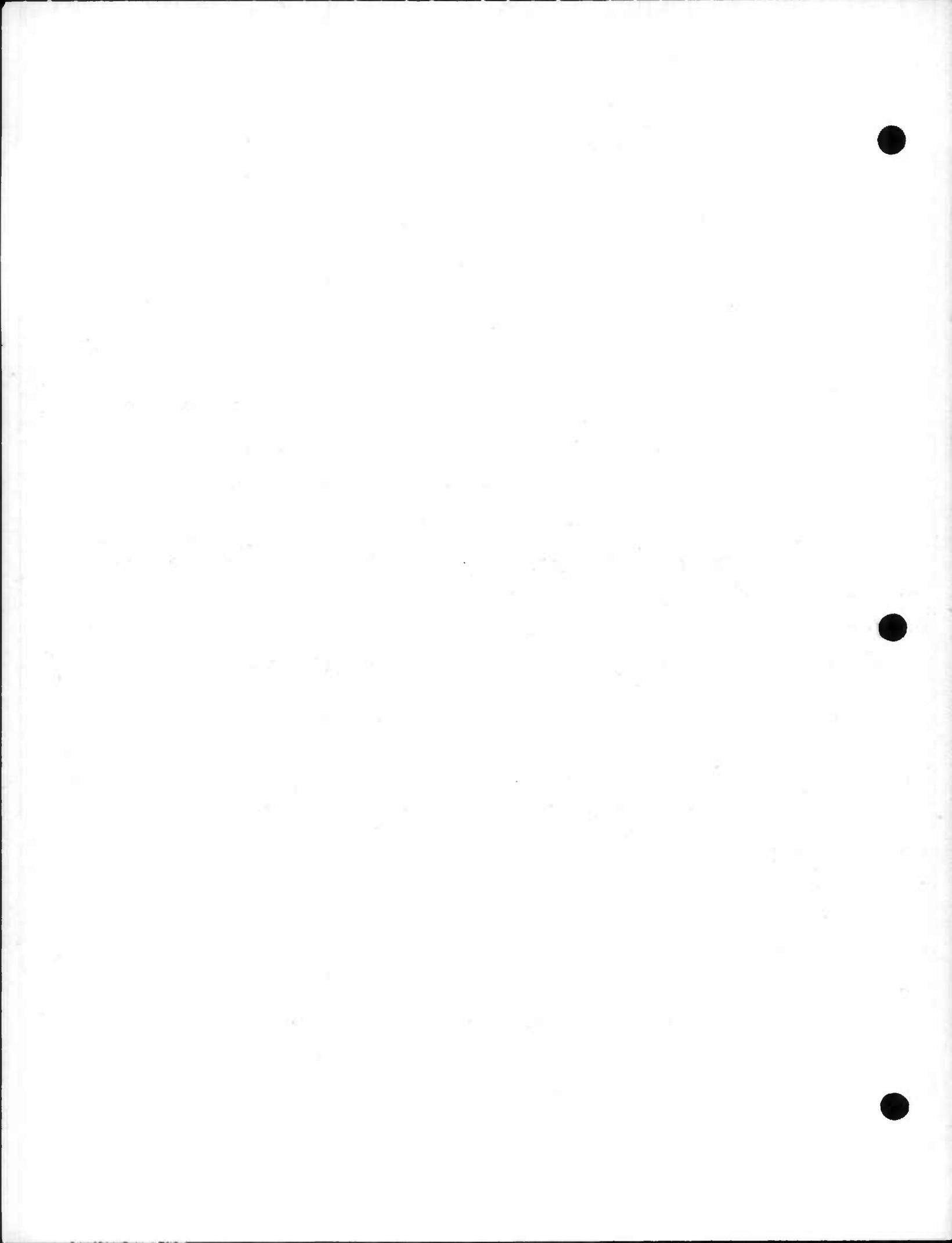
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.																																																								
1. DECEDENT'S NAME (First, Middle, Last) CURTIS SAMUEL STEUART												2. DATE OF DEATH MONTH MAY DAY 31 , 1995 YEAR	3. TIME OF DEATH 7:10 A M																																																							
4. SOCIAL SECURITY NUMBER 578.07.1164			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) APRIL 22, 1906	8. BIRTHPLACE (State or Foreign Country) WASHINGTON D.C.																																																												
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA					9c. COUNTY OF DEATH MONTGOMERY																																																												
RESIDENCE OF DECEDENT																																																																				
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION CHEVY CHASE					10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																												
10e. STREET AND NUMBER 6404 ELMWOOD ROAD			10f. ZIP CODE 20815					10g. CITIZEN OF WHAT COUNTRY? U.S.A.																																																												
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES +2			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: 			14. RACE — American Indian, Black, White, etc. Specify: WHITE																																																												
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) +2		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BUSINESSMAN			17b. KIND OF BUSINESS/INDUSTRY STEUART INVESTMENT CO.																																																															
17. FATHER'S NAME (First, Middle, Last) GUY STEUART						18. MOTHER'S NAME (First, Middle, Maiden Surname) ELLA JOHNSON																																																														
19a. INFORMANT'S NAME (Type/Print) FRANK T. STEUART				19b. MAILING ADDRESS (Street and Number or Rural Route Number; City or Town, State, Zip Code) 18798 RIDGEFIELD RD. N.W. SEATTLE WA 98177																																																																
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) GATE OF HEAVEN CEMETERY				20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or other place) GATE OF HEAVEN CEMETERY			DATE 6/2	20c. LOCATION — City or Town, State SILVER SPRING, MD.																																																												
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jean M. Peters				22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS 5130 WISCONSIN AVE. N.W. WASHINGTON D.C.																																																																
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																																																																				
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																																																																				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST																																																																				
<table border="0"> <tr> <td style="vertical-align: top;">a.</td> <td colspan="12">DUE TO (OR AS A CONSEQUENCE OF) Pneumonia</td> <td>Approximate Interval Between Onset and Death 9 days</td> </tr> <tr> <td style="vertical-align: top;">b.</td> <td colspan="12">DUE TO (OR AS A CONSEQUENCE OF) Congestive Heart failure</td> <td>Approximate Interval Between Onset and Death 9 days.</td> </tr> <tr> <td style="vertical-align: top;">c.</td> <td colspan="12">DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Heart disease</td> <td>Approximate Interval Between Onset and Death 8 years.</td> </tr> <tr> <td style="vertical-align: top;">d.</td> <td colspan="12">DUE TO (OR AS A CONSEQUENCE OF) Penile fracture</td> <td>Approximate Interval Between Onset and Death 9 days.</td> </tr> </table>													a.	DUE TO (OR AS A CONSEQUENCE OF) Pneumonia												Approximate Interval Between Onset and Death 9 days	b.	DUE TO (OR AS A CONSEQUENCE OF) Congestive Heart failure												Approximate Interval Between Onset and Death 9 days.	c.	DUE TO (OR AS A CONSEQUENCE OF) Coronary Artery Heart disease												Approximate Interval Between Onset and Death 8 years.	d.	DUE TO (OR AS A CONSEQUENCE OF) Penile fracture												Approximate Interval Between Onset and Death 9 days.
a.	DUE TO (OR AS A CONSEQUENCE OF) Pneumonia												Approximate Interval Between Onset and Death 9 days																																																							
b.	DUE TO (OR AS A CONSEQUENCE OF) Congestive Heart failure												Approximate Interval Between Onset and Death 9 days.																																																							
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PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																																																																				
<table border="0"> <tr> <td colspan="12">Cerebral Vasculitis - cerebral infarct occipital lobe</td> <td>24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> </tr> <tr> <td colspan="12">Cancer of Prostate</td> <td>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</td> </tr> </table>													Cerebral Vasculitis - cerebral infarct occipital lobe												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	Cancer of Prostate												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																														
Cerebral Vasculitis - cerebral infarct occipital lobe												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																								
Cancer of Prostate												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																																																								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																																																																				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 																																																																		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED																																																													
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29b. SIGNATURE AND TITLE OF CERTIFIER J. Blaine Fitzgerald		29c. LICENSE NUMBER DO-1948			29d. DATE SIGNED (Month, Day, Year) 5/31/95																																																															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. BLAINE FITZGERALD 8218 WISCONSIN AVE. BETHESDA, MD. 20814																																																																				
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE Jean M. Peters																																																																		



95 19174

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

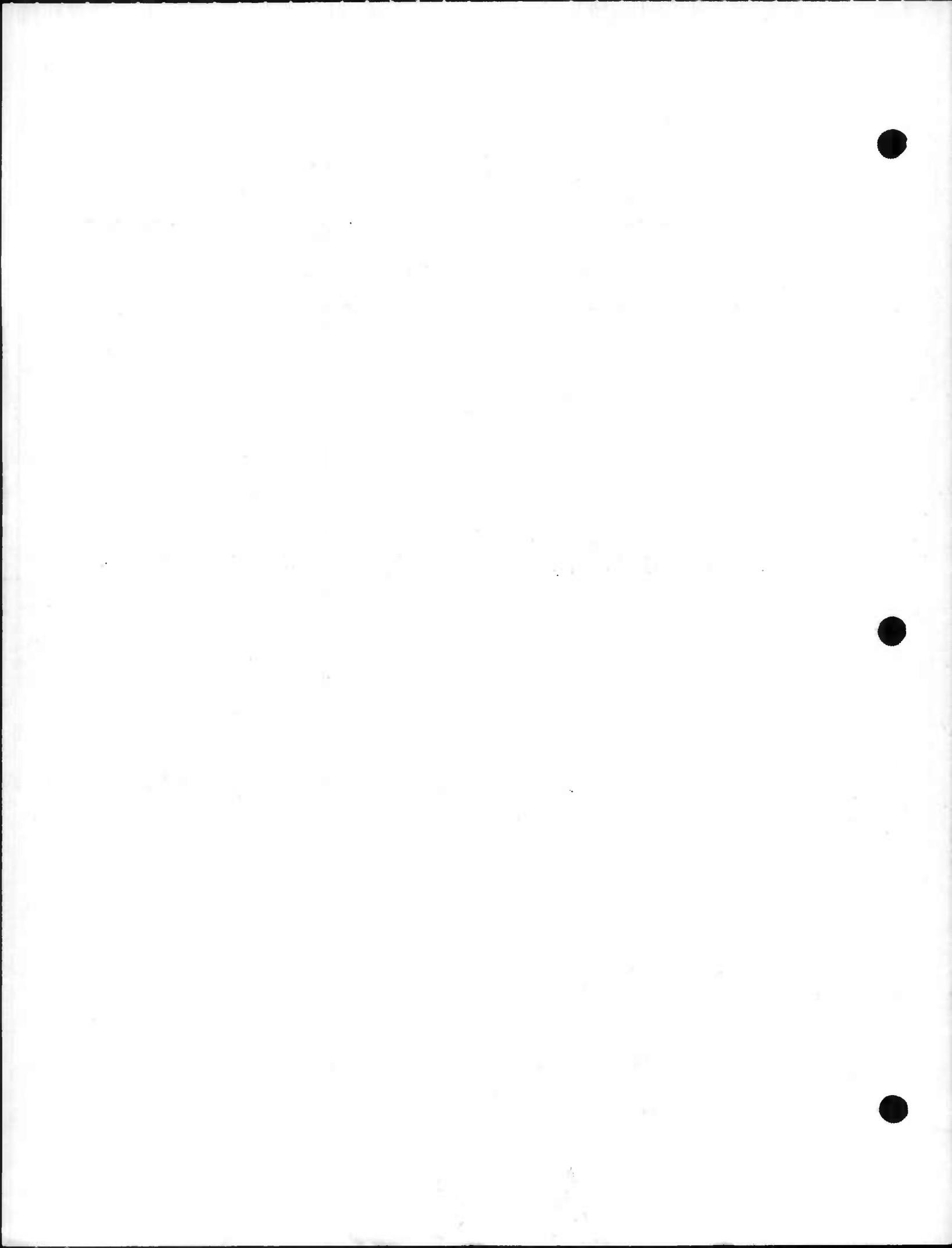
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - STATE REGISTRAR		Joe D. Simmons								2. DATE OF DEATH MONTH DAY YEAR			
										May 30 1995			
										3. TIME OF DEATH 1836 p.m.			
1. DECEDENT'S NAME (First, Middle, Last)		4. SOCIAL SECURITY NUMBER 413-56-7634		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 57 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 14, 1938			
9a. FACILITY NAME (If not institution, give street and number)		Shady Grove Adventist Hospital								8. BIRTHPLACE (State or Foreign Country) Georgia			
RESIDENCE OF DECEDENT		Rockville								9c. COUNTY OF DEATH Montgomery			
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Gaithersburg								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 10629 Seneca Ridge Drive		10f. ZIP CODE 20879								10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMEED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5+		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Physicist								14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Physicist								16b. KIND OF BUSINESS/INDUSTRY United States Government			
17. FATHER'S NAME (First, Middle, Last) James Corbett Simmons		18. MOTHER'S NAME (First, Middle, Maiden Surname) Fannie Lee Clemonns											
19a. INFORMANT'S NAME (Type/Print) Patricia A. Simmons		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10629 Seneca Ridge Drive, Gaithersburg, MD 20879											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.								20c. LOCATION — City or Town, State Bethesda, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara J. McMullen Lawrence		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. ventricular fibrillation OUE TO (OR AS A CONSEQUENCE OF): cardiomyopathy													
b. history of myocardial infarction OUE TO (OR AS A CONSEQUENCE OF): 5 years													
c. history of pulmonary embolus OUE TO (OR AS A CONSEQUENCE OF): 5 years													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
history of pulmonary embolus													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Roger Stevenson										29c. LICENSE NUMBER D-20535		29d. DATE SIGNED (Month, Day, Year) ► 5/31/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Roger Stevenson, Jr MD 6910 ROCKLEDGE DR #200 BETHESDA, MD 20817													
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE John Davidson Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

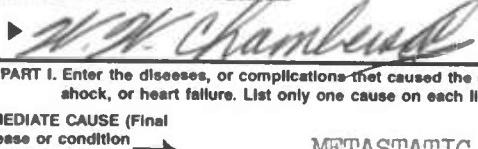
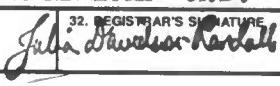
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

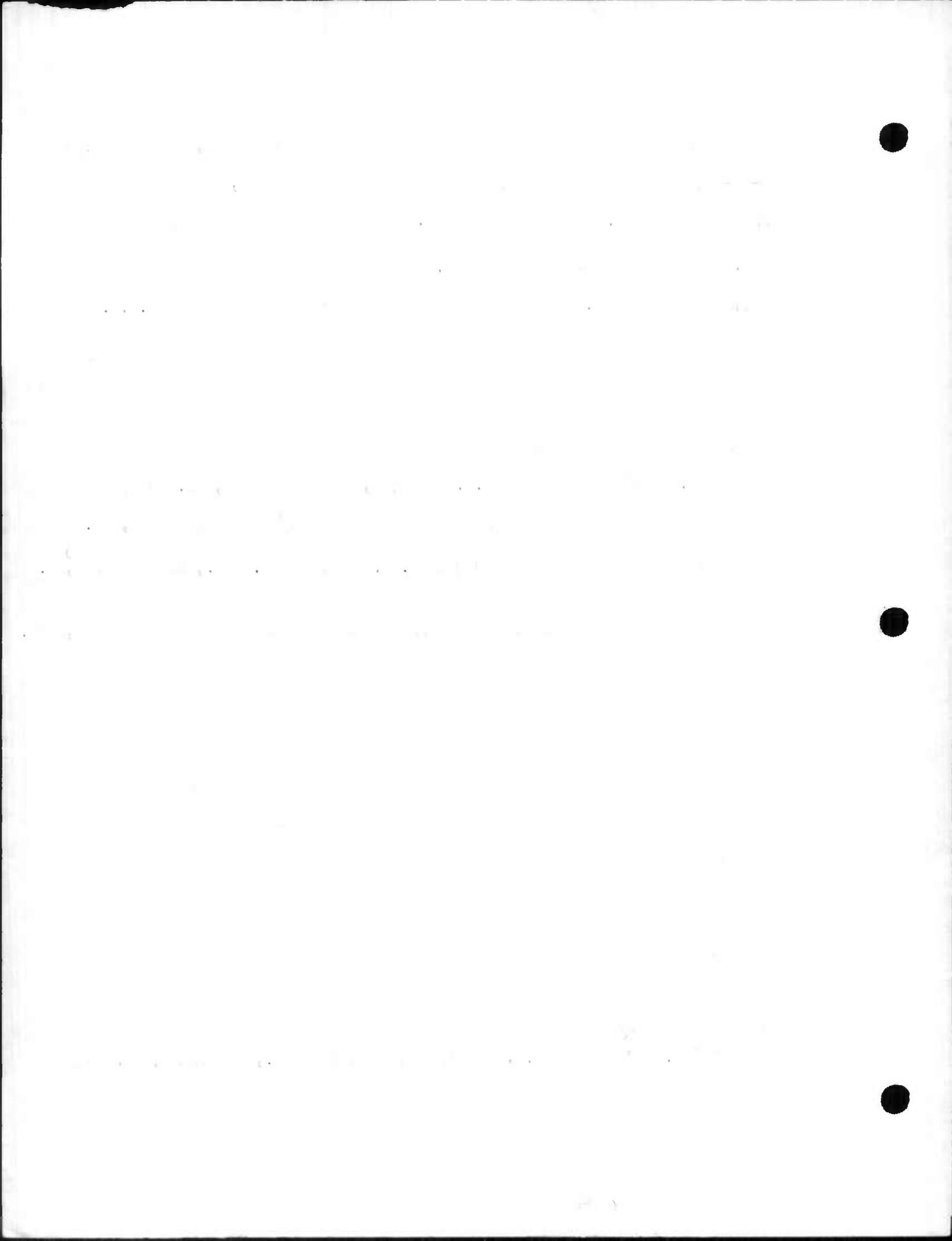
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH JUNE DAY 3, YEAR 1995	3. TIME OF DEATH 4:30 A.M.				
JACQUELINE KETLER STURGES												7. DATE OF BIRTH (Month, Day, Year) MAY 12, 1928		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
4. SOCIAL SECURITY NUMBER 220-24-9071			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.								
9a. FACILITY NAME (If not institution, give street and number) 7714 SAVANNAH DR.												9b. CITY, TOWN OR LOCATION OF DEATH W. BETHESDA		9c. COUNTY OF DEATH MONTGOMERY			
RESIDENCE OF DECEDENT												10e. STATE MD.		10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION W. BETHESDA	10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 7714 SAVANNAH DR.												10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) HOUSEWIFE			16b. KIND OF BUSINESS/INDUSTRY AT HOME											
17. FATHER'S NAME (First, Middle, Last) WILLIAM EDGAR KETLER						18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA WELLER											
19a. INFORMANT'S NAME (Type/Print) CARL R. STURGES						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 1725, WEST BETHESDA, MD. 20827											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORY			DATE 6/4		20c. LOCATION — City or Town, State RIVERDALE, MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD.											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 1 YR, 2 MO					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC NON SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF):																	
b. DUE TO (OR AS A CONSEQUENCE OF):																	
c. DUE TO (OR AS A CONSEQUENCE OF):																	
d. DUE TO (OR AS A CONSEQUENCE OF):																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)														
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. LICENSE NUMBER D37236										29d. DATE SIGNED (Month, Day, Year) JUNE 03, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CAROLYN B. HENDRICKS M.D.			32. REGISTRAR'S SIGNATURE 														
31. DATE FILED (Month, Day, Year) JUN 05 1995													DHMH-16 Rev 1/89				



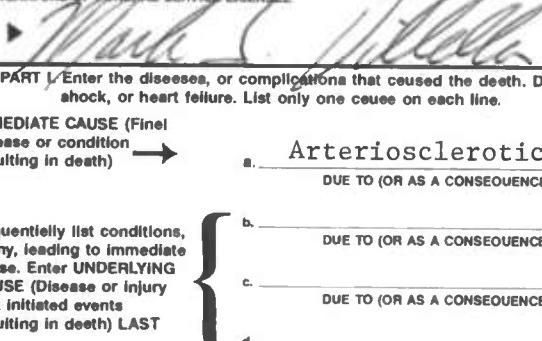
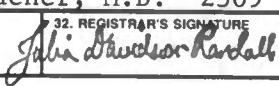
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

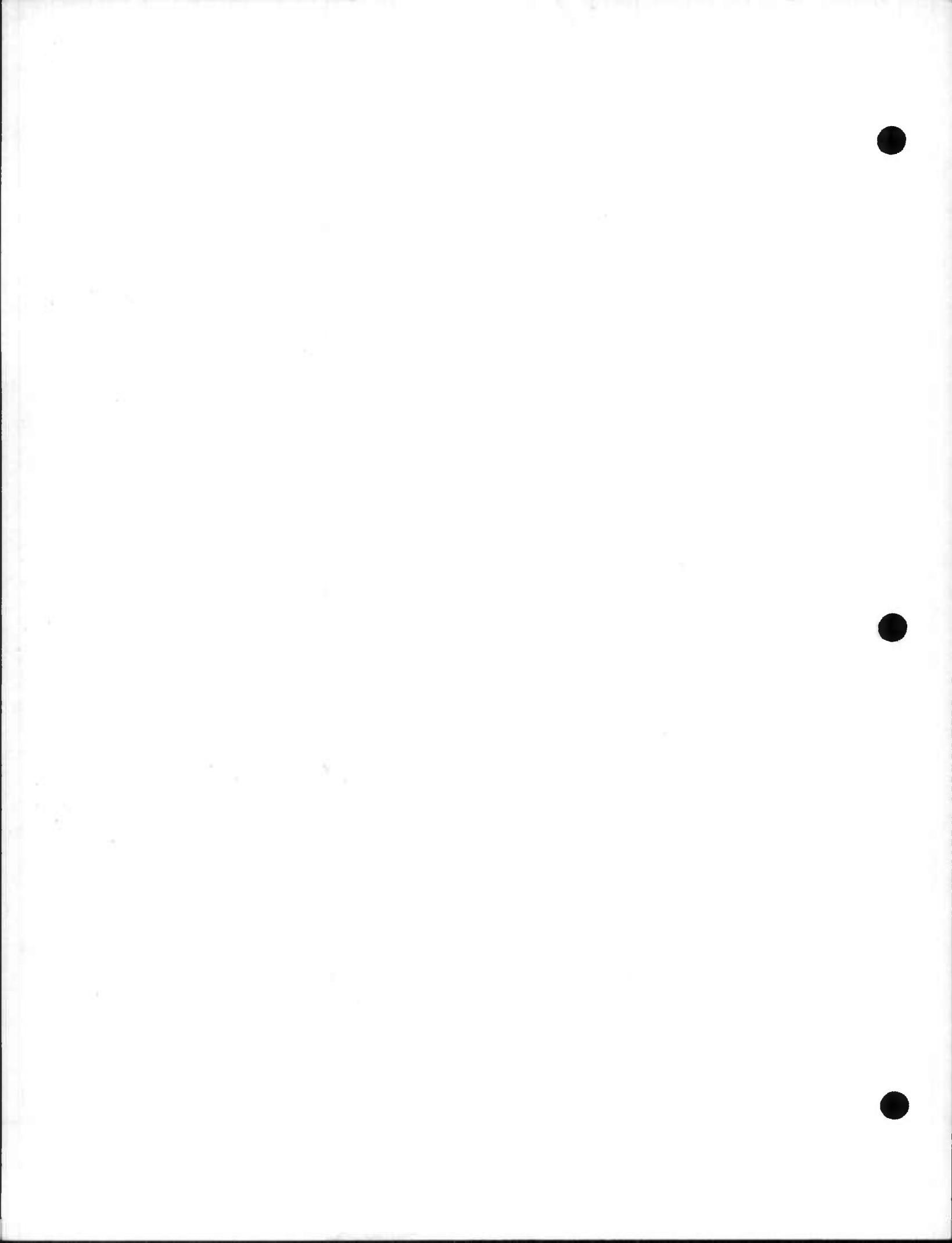
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEASED'S NAME (First, Middle, Last)																
EMMA HALASZ SCOTT																
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 11:55 A M				
062-03-0891		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		93 YRS.		MONTHS DAYS		HOURS MIN.		JUNE 3, 1995		8. BIRTHPLACE (State or Foreign Country) New York				
9a. FACILITY NAME (If not Institution, give street and number)	9b. CITY, TOWN OR LOCATION OF DEATH											9c. COUNTY OF DEATH				
Sylvan Manor Nursing Home	Silver Spring											Montgomery				
RESIDENCE OF DECEASED																
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
Maryland		Montgomery		Silver Spring												
10e. STREET AND NUMBER	10f. ZIP CODE											10g. CITIZEN OF WHAT COUNTRY? USA				
911 Laredo Road	20901															
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:									14. RACE — American Indian, Black, White, etc. Specify: White			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced																
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY												
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Financial Clerk		Financial Institution												
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)															
Julius Halasz	Emma Lechner															
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)														
D. June Quinn		P.O. Box 277 Kensington, MD 20895														
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE									20c. LOCATION — City or Town, State Woodside, New York			
		Calvary Cemetery		6/6/95												
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 20 Yrs.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) →	a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	{ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	b. _____ c. _____ d. _____															
Diabetes Mellitus	Disease											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
Peripheral Vascular																
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											24c. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24d. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED								
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D41931											29d. DATE SIGNED (Month, Day, Year) ► June 5, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)																
Ronald J. Schumacher, M.D. 2309 Shorefield Road, Wheaton, MD 20902																
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 														



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

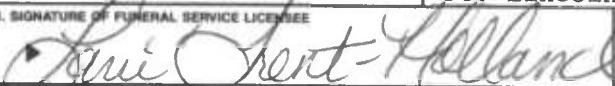
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

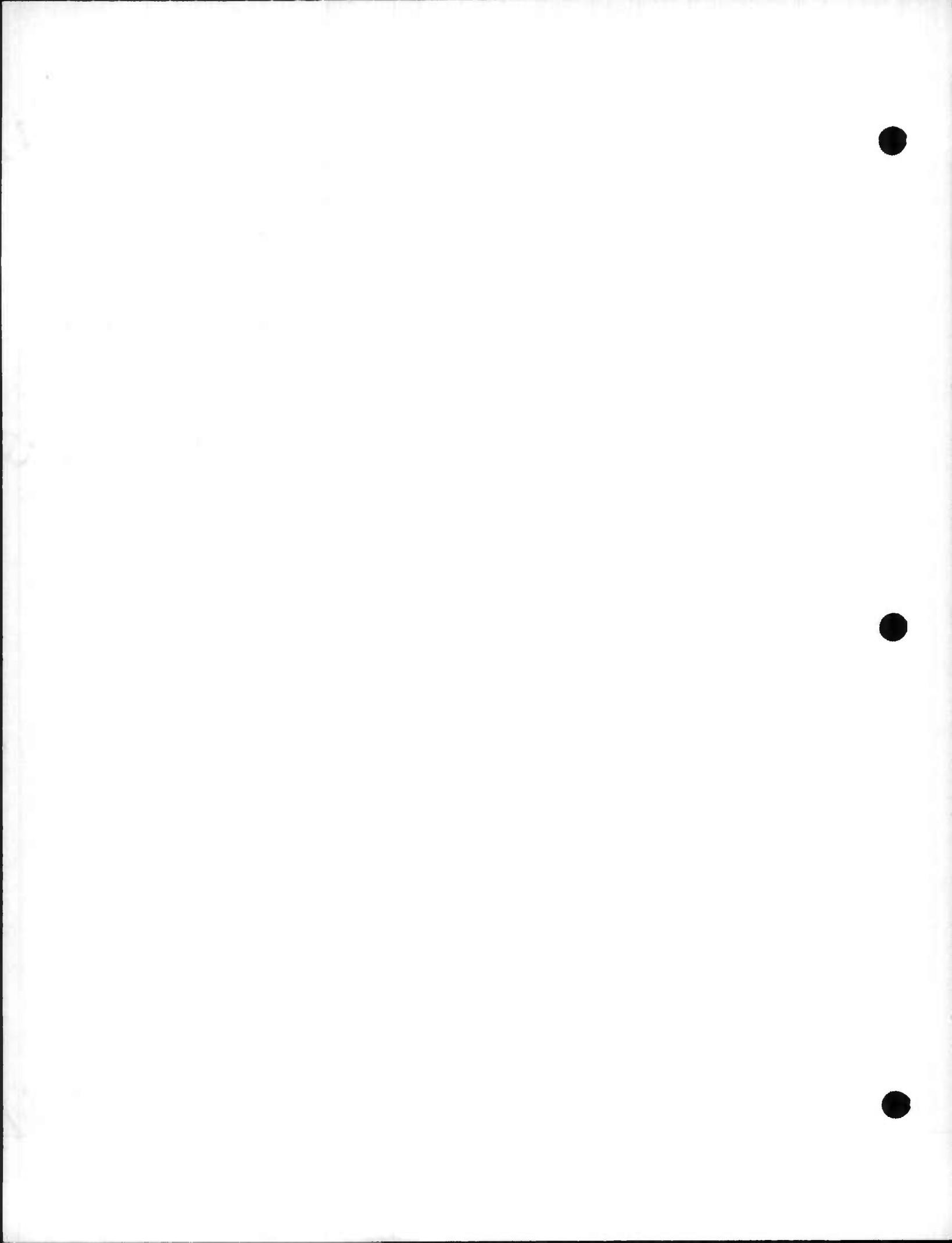
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19177

1. DECEDENT'S NAME (First, Middle, Last) JAMES WILLIAM SHEPARD						2. DATE OF DEATH MONTH JUNE 5, DAY 1995 YEAR	3. TIME OF DEATH 10:20 AM _M
4. SOCIAL SECURITY NUMBER 174-07-7799		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 8, 1912	
8a. FACILITY NAME (If not institution, give street and number) 3200 Spartan Road, Apt. 1						8b. CITY, TOWN OR LOCATION OF DEATH Olney	
9c. COUNTY OF DEATH Montgomery						8d. BIRTHPLACE (State or Foreign Country) Pennsylvania	
RESIDENCE OF DECEDENT							
10a. STATE MD	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Olney				
10e. STREET AND NUMBER 3200 Spartan Road, Apt. 1				10f. ZIP CODE 20832		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1946		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0 Laborer		16b. KIND OF BUSINESS/INDUSTRY Private Sector/Factory			
17. FATHER'S NAME (First, Middle, Last) Tobias Shepard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Blanche Hoxie			
19a. INFORMANT'S NAME (Type/Print) Jerry W. Shepard				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17500 MacDuff Avenue, Olney, MD 20832			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Crematory		DATE 6/7/95		20c. LOCATION — City or Town, State Brentwood, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave Silver Spring MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):							
b. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF):							
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D23459					
		29d. DATE SIGNED (Month, Day, Year) ► June 6, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Edward Taubman; 18111 Prince Philip Drive, Olney, MD							
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

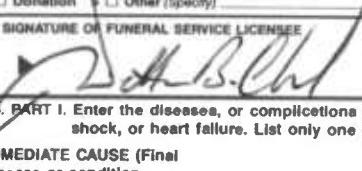
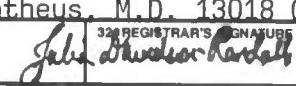
TO BE COMPLETED BY FUNERAL DIRECTOR

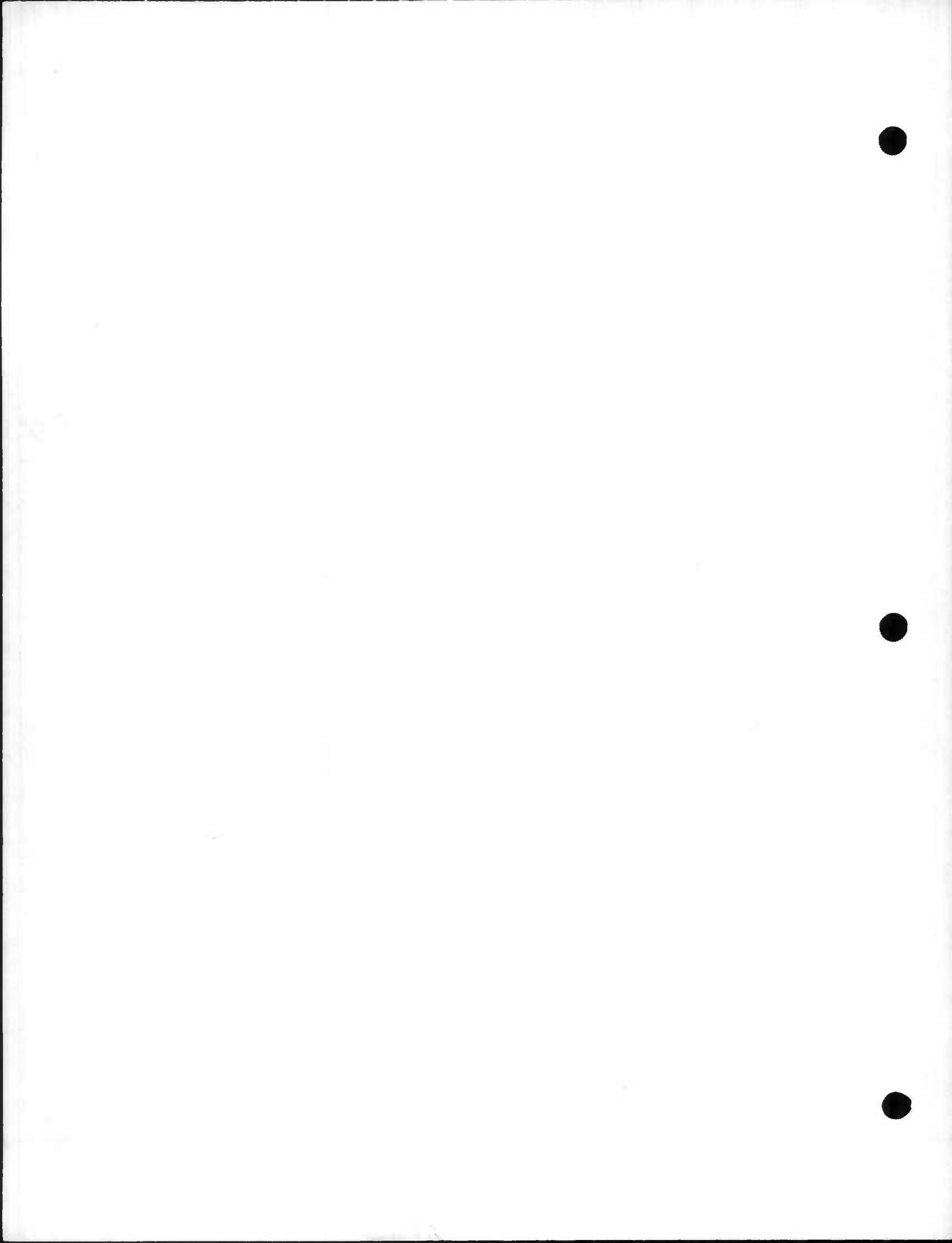
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19178

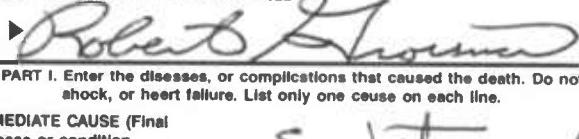
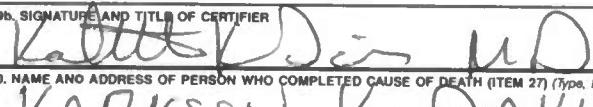
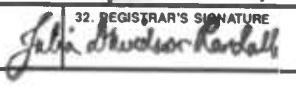
1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH 7:10 P M	
Celia Simon				June 7, 1995					
4. SOCIAL SECURITY NUMBER 112-01-7513		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept 19, 1912	
9a. FACILITY NAME (If not institution, give street and number) Meridian at Aspenwood		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery		8. BIRTHPLACE (State or Foreign Country) New York			
RESIDENCE OF DECEASED									
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Burtonsville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 14620 Almanac Drive			10f. ZIP CODE 20866			10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Joseph Karash				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose (Unavailable)					
19a. INFORMANT'S NAME (Type/Print) Brenda S. Wheaton (Daughter)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Lebanon Cemetery		DATE 6-9		20c. LOCATION — City or Town, State Adelphi, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 									
22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P. A. 933 Gist Avenue, Silver Spring, MD 20910									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):									
b. Pneumonia and Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):									
c. _____ DUE TO (OR AS A CONSEQUENCE OF):									
d. _____									
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
Diabetes Multi-infarction Dementia				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D-18924							
29d. DATE SIGNED (Month, Day, Year) June 8, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rafael A. Matheus, M.D. 13018 Georgia Avenue, Wheaton, MD 20906									
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 							



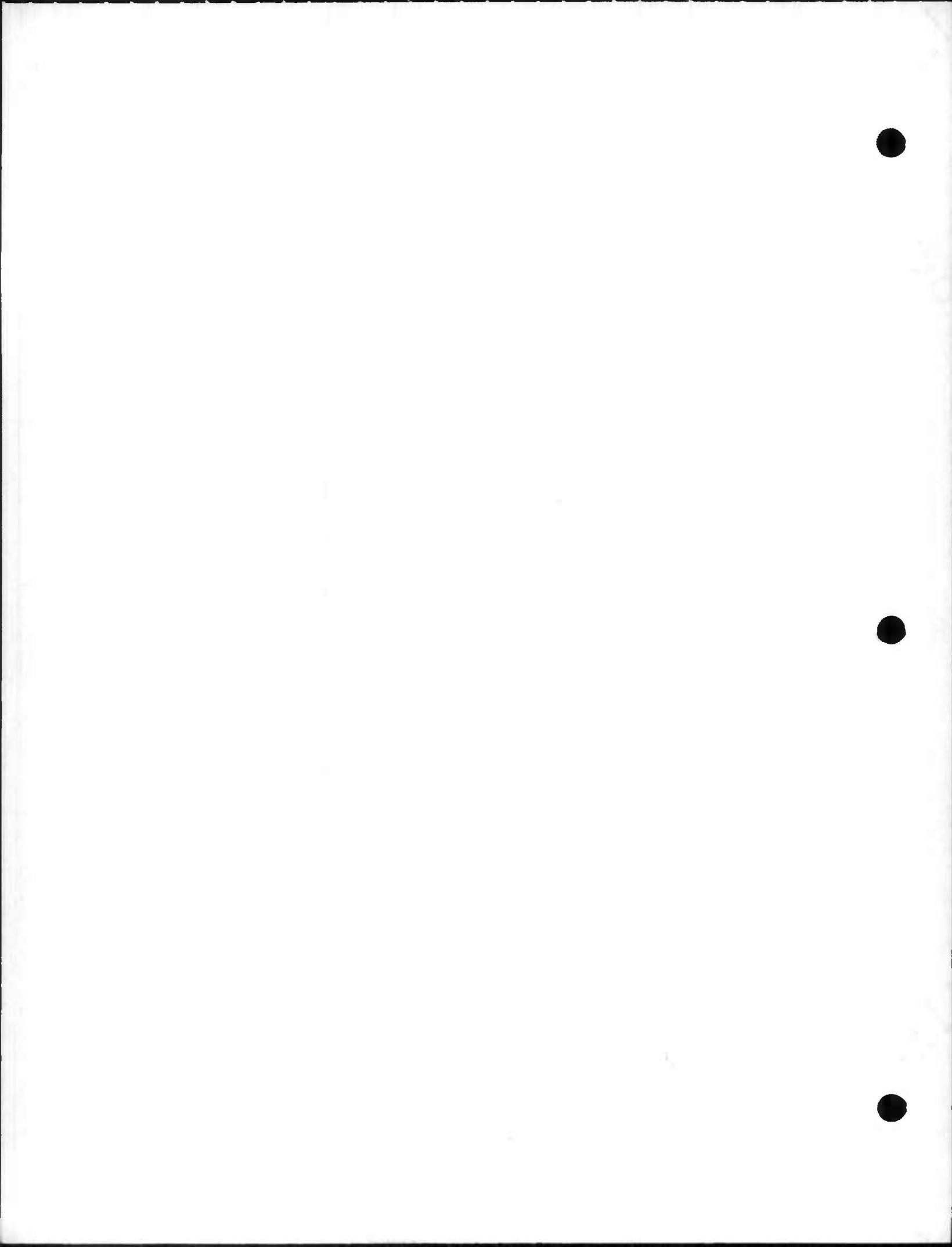
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) YETTA SCHIFF												2. DATE OF DEATH MONTH JUNE DAY 7, 1995 YEAR	3. TIME OF DEATH 12:15 A M
4. SOCIAL SECURITY NUMBER 064-10-0805		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) AUG 7, 1910	8. BIRTHPLACE (State or Foreign Country) NEW YORK						
9a. FACILITY NAME (If not institution, give street and number) 1316 FENWICK LANE #817						9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING			9c. COUNTY OF DEATH MONTGOMERY				
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION SILVER SPRING											
10e. STREET AND NUMBER 1316 FENWICK LANE, #817						10f. ZIP CODE 20910			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced X		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NURSE			16b. KIND OF BUSINESS/INDUSTRY HEALTH							
17. FATHER'S NAME (First, Middle, Last) AARON KULLMAN						18. MOTHER'S NAME (First, Middle, Maiden Surname) RAY PAPERLY							
19a. INFORMANT'S NAME (Type/Print) BASIL SCHIFF (SON)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6952 DUNCRAIG COURT, MCLEAN, VA 22101							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH DAVID			DATE 6/11			20c. LOCATION — City or Town, State ELMONT, NEW YORK				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MD 20852							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Approximate Interval Between Onset and Death	
<p>a. <i>End stage Alzheimer's Dementia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i> DUE TO (OR AS A CONSEQUENCE OF):</p>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN X													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/> Pending investigation											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  KATHLEEN D. DAVIS M.D.										29c. LICENSE NUMBER 037096	29d. DATE SIGNED (Month, Day, Year) JUNE 7, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KATHLEEN D. DAVIS 8700 GEORGIA AVE SILVER SPRING, MD.													
31. DATE FILED (Month, Day, Year) JUN 09 1995				32. REGISTRAR'S SIGNATURE 									

20



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

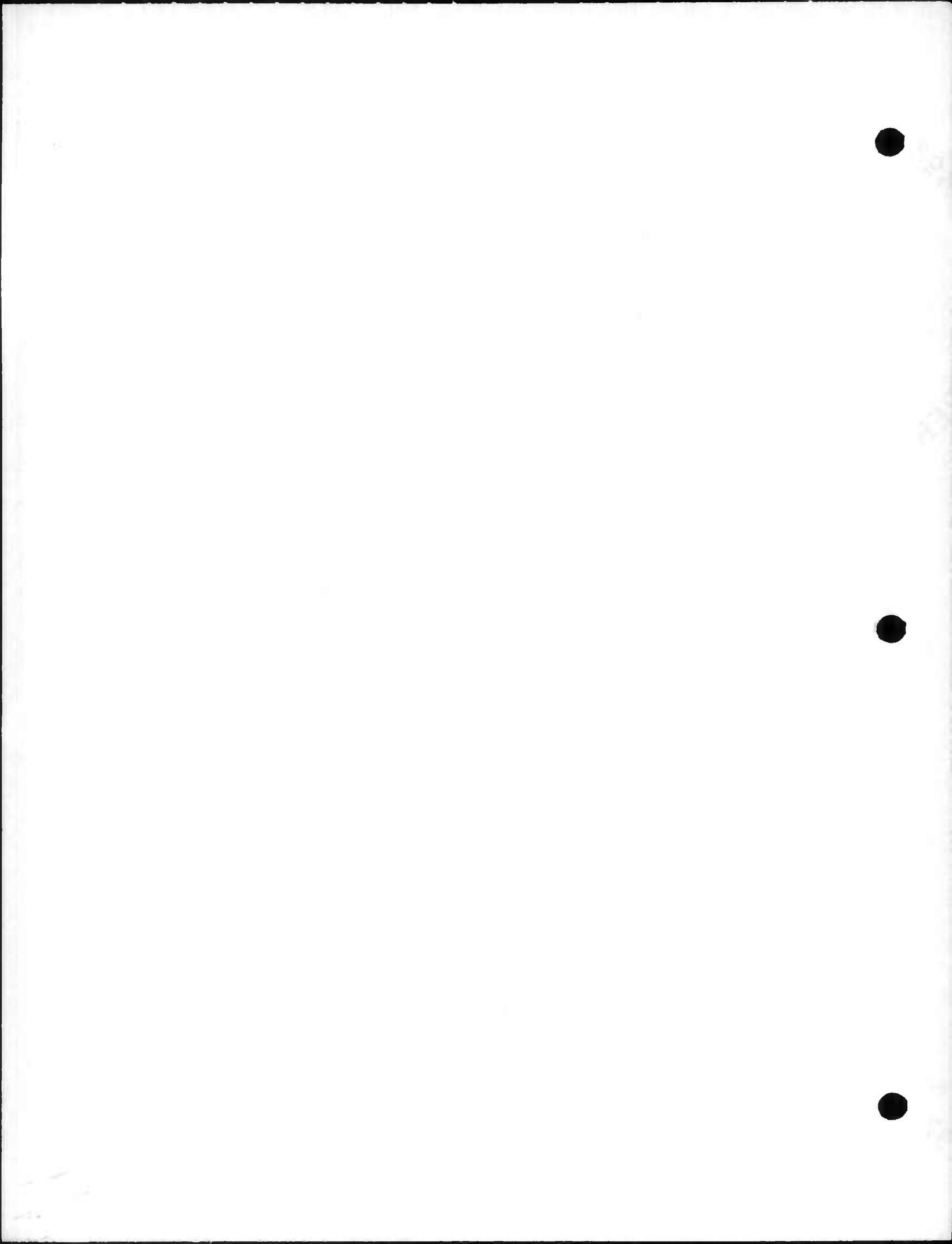
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)		WILLIAM WAYNE SLADEN								2. DATE OF DEATH MONTH JUNE DAY 6 YEAR 1995		3. TIME OF DEATH 11 05 PM			
4. SOCIAL SECURITY NUMBER 215-46-1082		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 30, 1944		8. BIRTHPLACE (State or Foreign Country) Washington, DC			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring								9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT															
10a. STATE Georgia		10b. COUNTY Effingham		10c. CITY, TOWN OR LOCATION Rincon								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1591 Ebenezer Road								10f. ZIP CODE 31326				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1965-1969		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White								14. RACE — American Indian, Black, White, etc. Specify:			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 2 College (1-4 or 5+)		16b. KIND OF BUSINESS/INDUSTRY Service Foreman Gulf Stream Aerospace											
17. FATHER'S NAME (First, Middle, Last) Yates S. Sladen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence E. Upperman											
19a. INFORMANT'S NAME (Type/Print) Florence E. Sladen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13118 Bluehill Rd., Silver Spring, MD 20906											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Parklawn Cemetery				20c. DATE 6/10/95				20c. LOCATION — City or Town, State Rockville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy G. Campbell				22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W., Sil.Spr.MD 20901											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 6 MONTHS			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myelogenous Leukemia DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST															
{ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D07285		29d. DATE SIGNED (Month, Day, Year) ► 6/11/95											
29b. SIGNATURE AND TITLE OF CERTIFIER James G. Brown, MD		29c. LICENSE NUMBER D07285		29d. DATE SIGNED (Month, Day, Year) ► 6/11/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James G. Brown MD 9707 Medical Center Drive, Rockville, MD 20850		32. REGISTRAR'S SIGNATURE Julie Deacon-Karall													
31. DATE FILED (Month, Day, Year) JUN 09 1995															



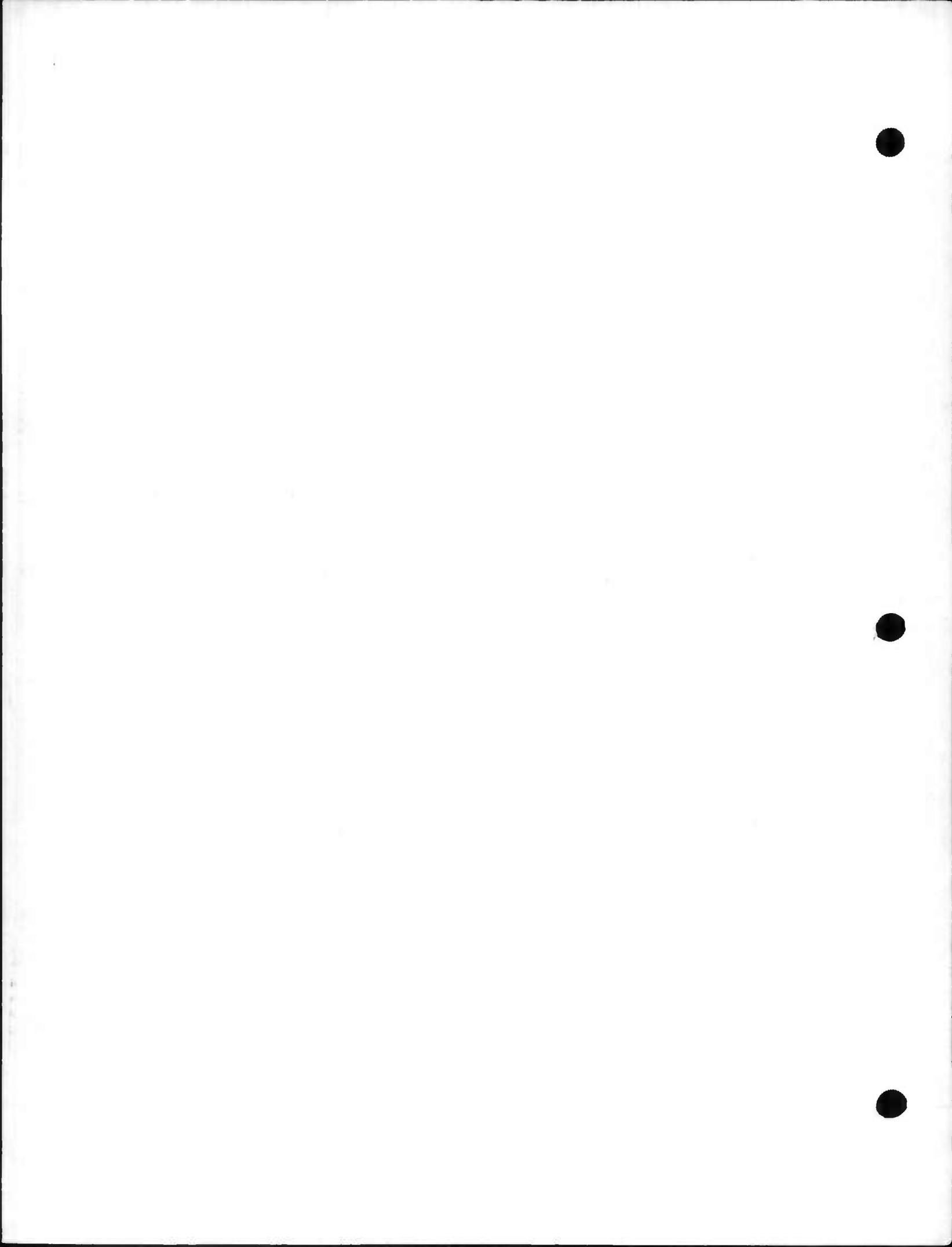
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or if item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**TO BE COMPLETED BY FUNERAL DIRECTOR**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) Veronica H. Sullivan											2. DATE OF DEATH MONTH JUNE DAY 5 YEAR 1995	3. TIME OF DEATH 8:10 A.M.
4. SOCIAL SECURITY NUMBER 217-36-3066		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Dec. 15, 1911	8. BIRTHPLACE (State or Foreign Country) New York						
9a. FACILITY NAME (If not institution, give street and number) Brooke Grove Nursing Center				9b. CITY, TOWN OR LOCATION OF DEATH Olney			9c. COUNTY OF DEATH Montgomery					
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Olney			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 17100 Thorntondale Court				10f. ZIP CODE 20832			10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse			16b. KIND OF BUSINESS/INDUSTRY Hospital							
17. FATHER'S NAME (First, Middle, Last) David Holland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bridgette Kelly								
19a. INFORMANT'S NAME (Type/Print) Mary Ann McGarry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17100 Thorntondale Court, Olney, Maryland 20832								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cemetery			20c. DATE June 12, 1995			20c. LOCATION — City or Town, State Arlington, Virginia				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Barbara J. McMullen Lawrence				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805								
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 3 DAYS		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → END STAGE EMPYSEMA DUE TO (OR AS A CONSEQUENCE OF):												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {												
b. DUE TO (OR AS A CONSEQUENCE OF):												
c. DUE TO (OR AS A CONSEQUENCE OF):												
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)										
		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER TED E. HOWE, MD		29c. LICENSE NUMBER D33700						29d. DATE SIGNED (Month, Day, Year) JUNE 5, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) TED E. HOWE, MD												
31. DATE FILED (Month, Day, Year) JUN 08 1995		32. REGISTRAR'S SIGNATURE Jane A. Johnson Marshall										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

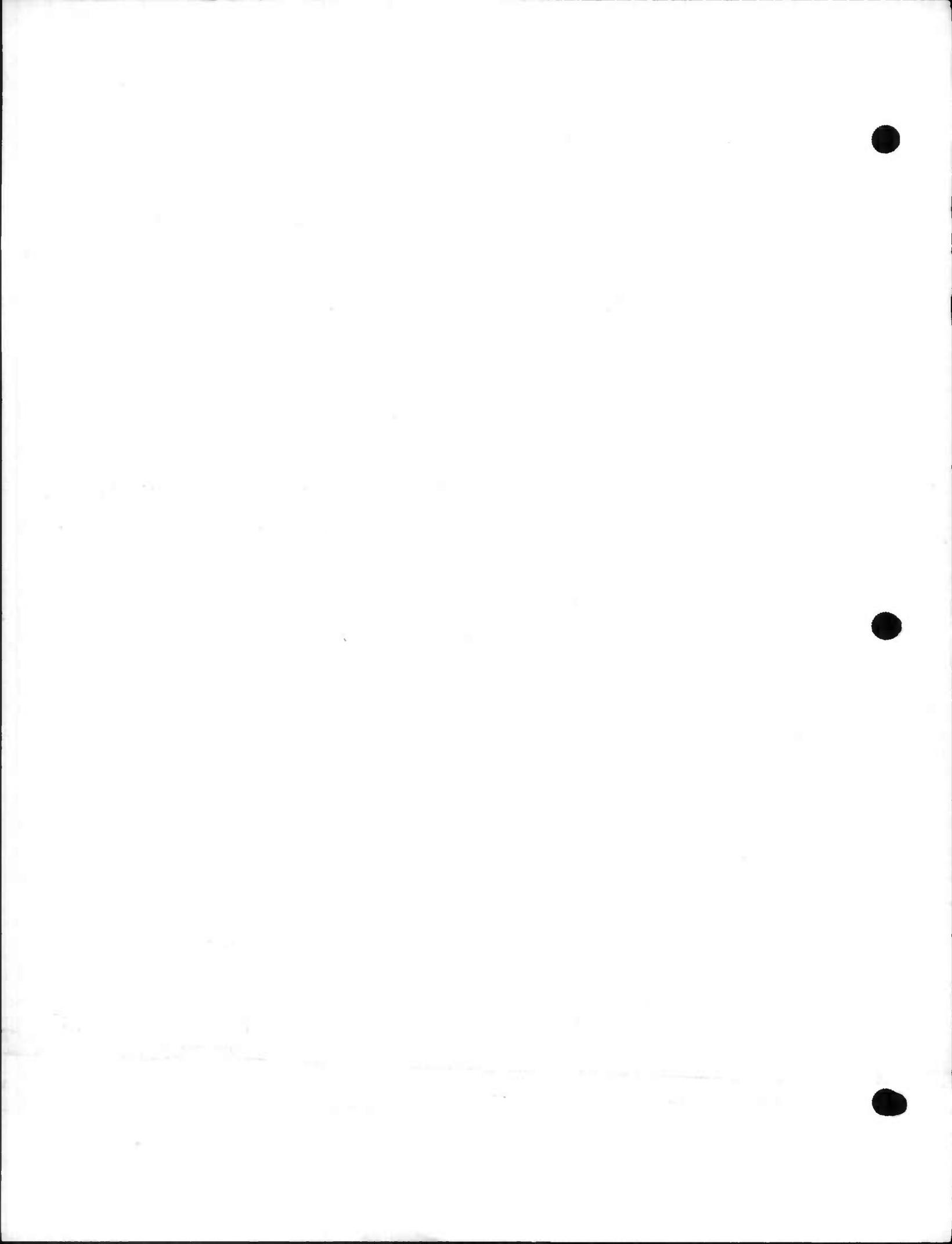
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19182

1. DECEDENT'S NAME (First, Middle, Last) LEROY ANDREW SELLIER						2. DATE OF DEATH MONTH DAY YEAR JUN 9 1995	3. TIME OF DEATH 11-29A M
4. SOCIAL SECURITY NUMBER 216 24 2326		5. SEX M	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) FEB 14 1929	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) SQ FALLSTON GEN Hosp						9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON	9c. COUNTY OF DEATH HARFORD
10e. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Street		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 615 Cherry Hill Road				10f. ZIP CODE 21154		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Care Taker		16b. KIND OF BUSINESS/INDUSTRY youth camp maintenance			
17. FATHER'S NAME (First, Middle, Last) August (u/k) Sellier				18. MOTHER'S NAME (First, Middle, Maiden Surname) Veronica (u/k) Arman			
19e. INFORMANT'S NAME (Type/Print) Jean D. Sellier				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 615 Cherry Hill Road, Street, Maryland 21154			
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens 6/13/95		DATE	20c. LOCATION — City or Town, State Bel Air, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stacy A. Hucks				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. A WSTE CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): AS WD.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. AS WD. DUE TO (OR AS A CONSEQUENCE OF): c. Exogenous obesity DUE TO (OR AS A CONSEQUENCE OF): d. Exogenous obesity							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Exogenous obesity							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: NA OTHER: NA		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) NA		28b. TIME OF INJURY NA M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED NA	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) NA		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) NA					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 21809		29d. DATE SIGNED (Month, Day, Year) ► 6-9-1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Garrison Lee Dye		32. REGISTRAR'S SIGNATURE Judy Dawson Marshall					
31. DATE FILED (Month, Day, Year) JUN 12 1995							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

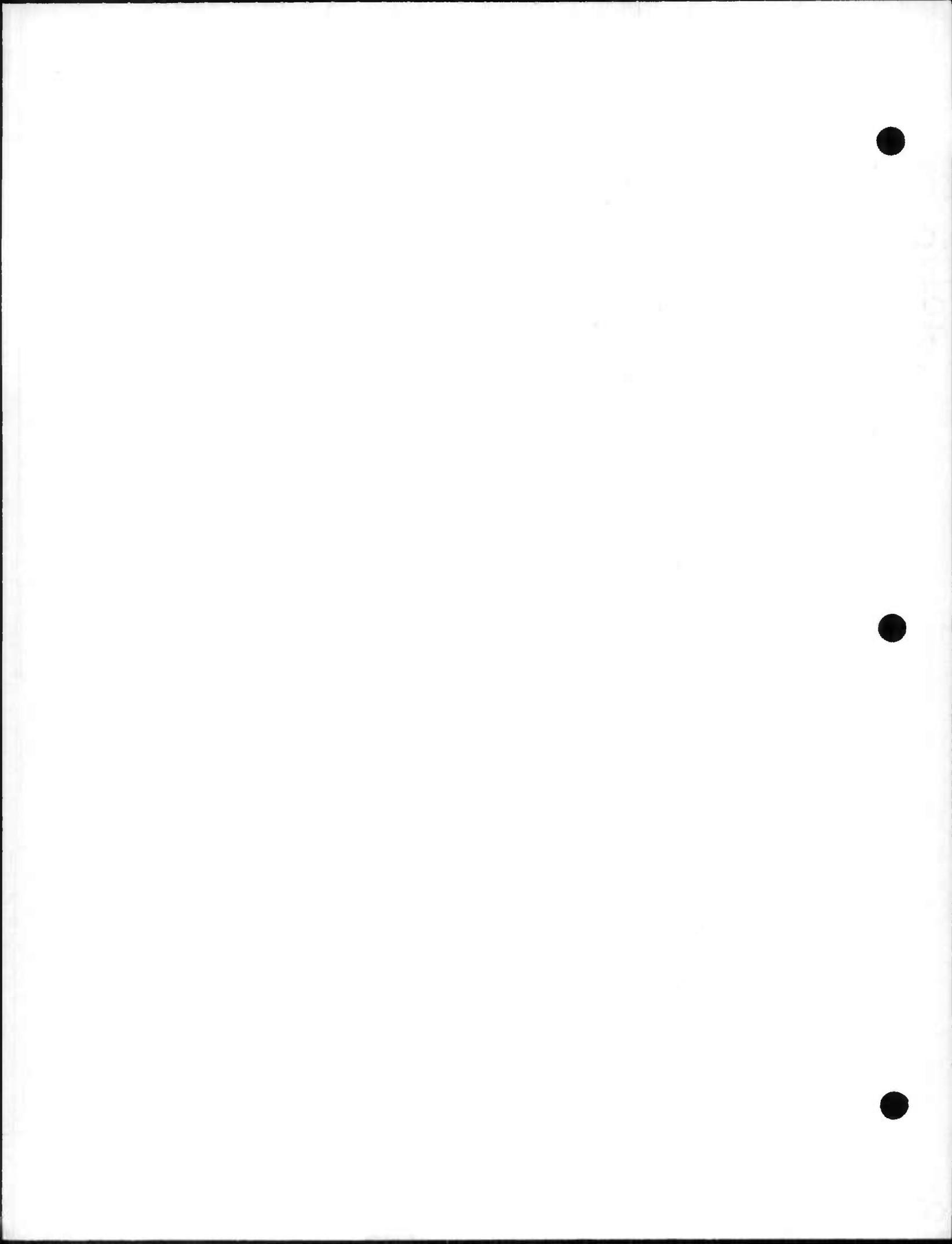
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19183

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH		3. TIME OF DEATH	
Ruby Lowndes Stecher						MONTH DAY YEAR		9:20 A M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH	
212-66-4009		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	83 YRS.	MONTHS	DAYS	HOURS	MIN.	(Month, Day, Year)	
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
Physicians Memorial Hospital						La Plata		Charles	
RESIDENCE OF DECEDENT									
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Maryland	Charles	Nanjemoy				<input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
1775 Liverpool Point Road				20662		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY				
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Homemaker			Home				
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Charles Hendricks Thomas						Mary Waring Perrie Thomas			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
William T. Stecher				20905 14613 Cobble Stone Drive, Silver Spring, MD					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE		20c. LOCATION — City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Cedar Hill Cemetery			6/12		Suitland, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
M00817 ▶ Guyton C. Scholl III				Arehart-Echols Funeral Home, Inc. P.O. Box 567 La Plata, MD 20646					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
<p>a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Pneumonia</p> <p>b. Acute cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): Hypertension</p> <p>Approximate Interval Between Onset and Death: 3-4 days 22 days years</p>									
<p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>{</p>									
<p>D. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Diabetes mellitus, Acute myocardial infarction</p>									
<p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></p>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		<p>HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
<p>1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide</p>									
29a. CERTIFIER (Check only one)		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
2 <input type="checkbox"/> MEDICAL EXAMINER		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)					
B. Larry Jenkins, M.D.		D-33426		▶ 6/8/95					
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE							
JUN 12 1995		Julie Anderson Harrell							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
111 La Grange Avenue, PO Box 1724 La Plata, Maryland 20646									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

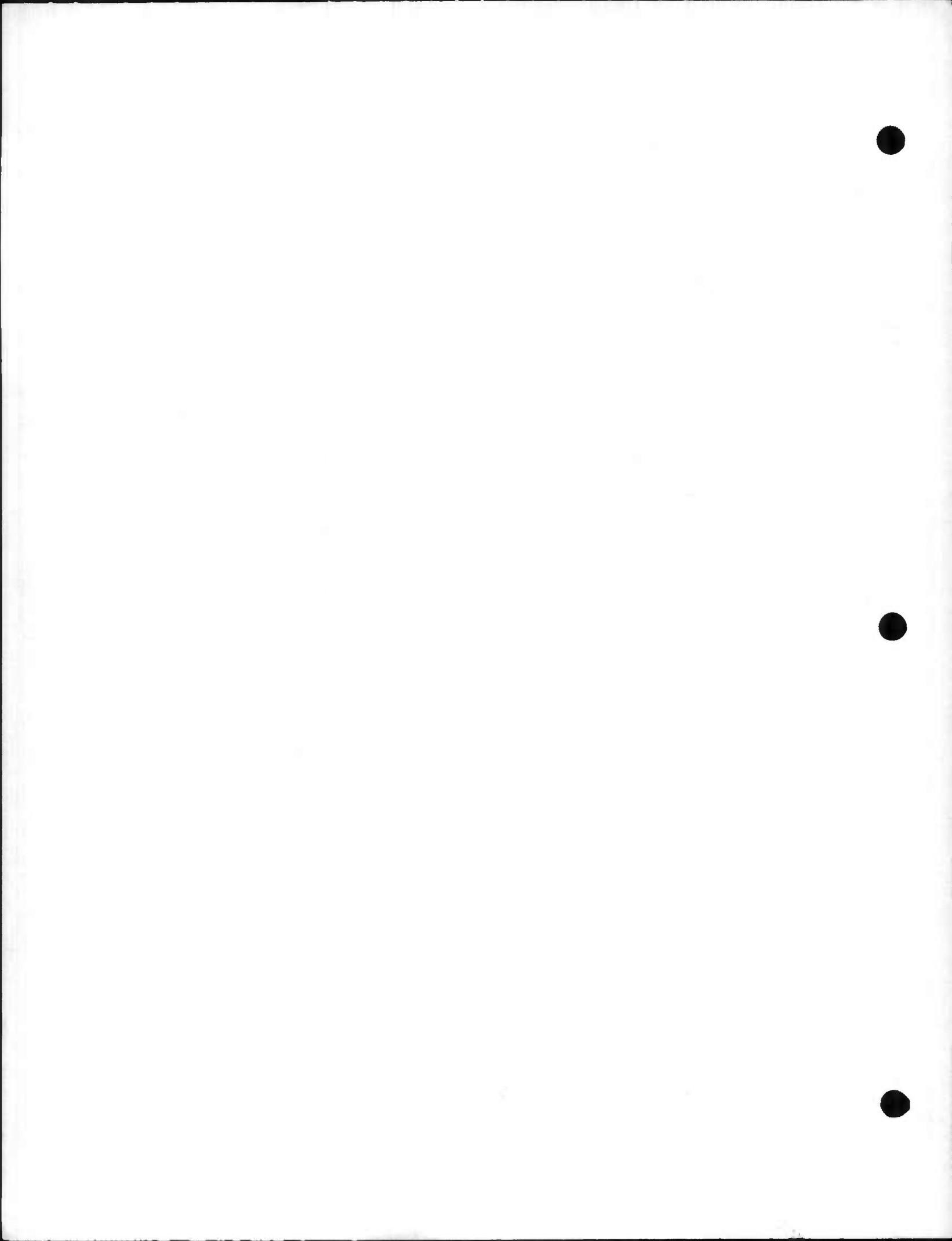
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		CHARLES SUKALO						2. DATE OF DEATH MONTH JUNE DAY 2 YEAR 1995		3. TIME OF DEATH 6:30 A.M.	
4. SOCIAL SECURITY NUMBER 199-09-1728		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS			
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND HOSPITAL								7. DATE OF BIRTH (Month, Day, Year) 8/8/19		8. BIRTHPLACE (State or Foreign Country) New Jersey	
9b. CITY, TOWN OR LOCATION OF DEATH Clinton								9c. COUNTY OF DEATH Prince George			
RESIDENCE OF DECEASED											
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Lothian						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5826 Sonny Drive								10f. ZIP CODE 20711		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+		16b. KIND OF BUSINESS/INDUSTRY Retired Federal Gov't Patent Attorney							
17. FATHER'S NAME (First, Middle, Last) George Sukalo										18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Mamchits	
19a. INFORMANT'S NAME (Type/Print) Elaine A. Sukalo		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) same as item 10						20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Trinity Russian Orthodox	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>J.P. Kalas</i>								20c. DATE 6/5/95		20c. LOCATION — City or Town, State Elkridge, Md.	
22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF)								5 years	
		b. Coronary heart disease DUE TO (OR AS A CONSEQUENCE OF):									
		c. _____ DUE TO (OR AS A CONSEQUENCE OF):									
		d. _____									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> MEDICAL EXAMINER		29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. A. Alleslani</i>								29c. LICENSE NUMBER D10868	
										29d. DATE SIGNED (Month, Day, Year) June 2, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) No HAMMAD TALE CATANI 4467 OLD BRANCH AVENUE TEMPLE HILLS 20748											
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE <i>Susan Dawson-Randall</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

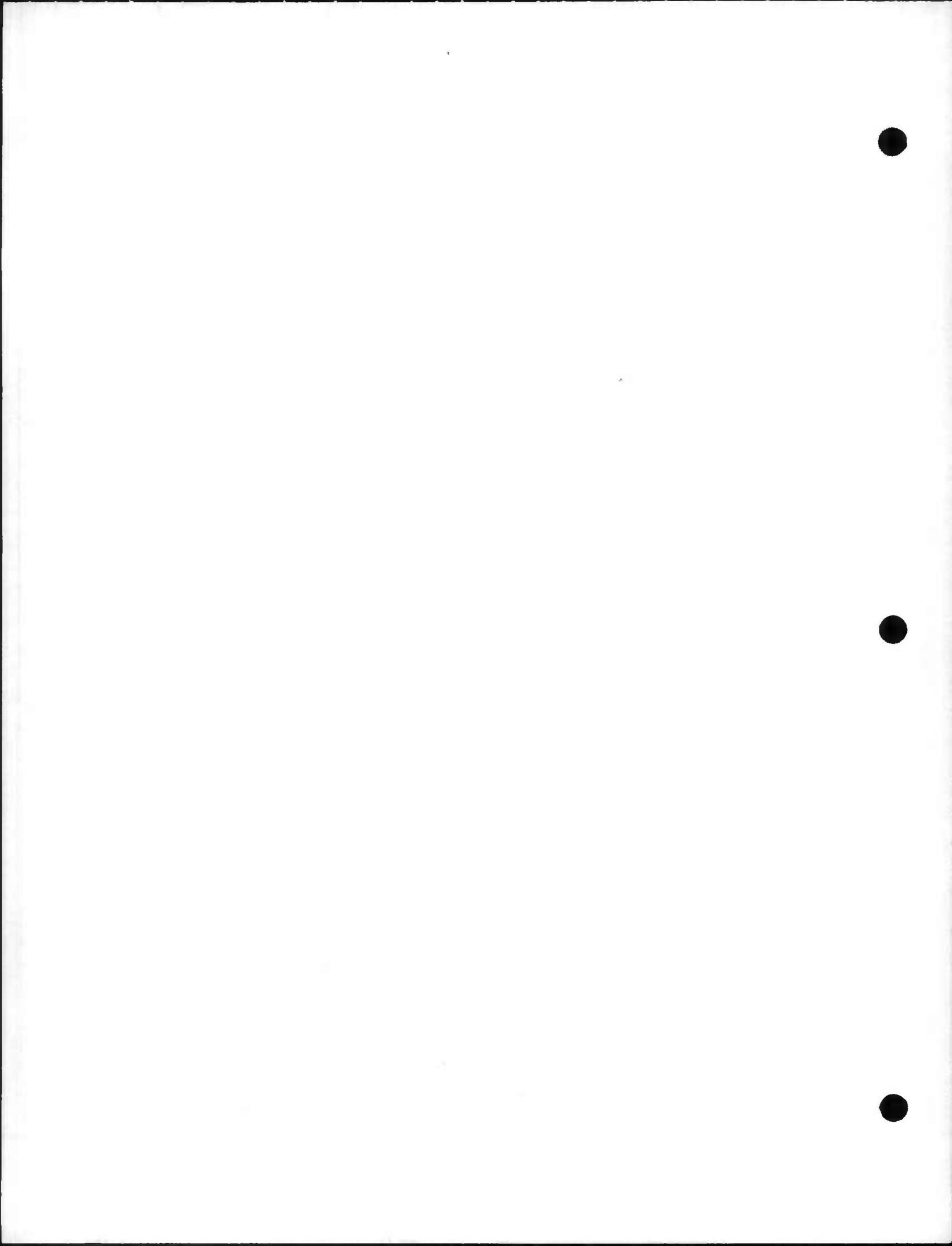
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) MARGUERITE A. SCHNEIDER											2. DATE OF DEATH MONTH DAY YEAR MAY 30, 1995	3. TIME OF DEATH 10.00P M
4. SOCIAL SECURITY NUMBER 169 22 3236		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 28, 1921		8. BIRTHPLACE (State or Foreign Country) Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly				9c. COUNTY OF DEATH Prince George's				
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 15587 Peach Walker Drive					10f. ZIP CODE 20716			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Medical Technologist		16b. KIND OF BUSINESS/INDUSTRY P.G. Hospital								
17. FATHER'S NAME (First, Middle, Last) John Kopfinger					18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Long							
19a. INFORMANT'S NAME (Type/Print) Philip F. Schneider					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15587 Peach Walker Drive Bowie Maryland 20716							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resurrection Cemetery			DATE 6/3/95	20c. LOCATION — City or Town, State Clinton Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.					22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. <u>Multisystem Failure</u> DUE TO (OR AS A CONSEQUENCE OF):												
b. <u>Bowel infarction</u> DUE TO (OR AS A CONSEQUENCE OF):												
c. <u>Occlusion of celiac artery</u> DUE TO (OR AS A CONSEQUENCE OF):												
d. <u>Atherosclerotic vascular disease</u> DUE TO (OR AS A CONSEQUENCE OF):												
Approximate Interval Between Onset and Death 3 weeks												
Approximate Interval Between Onset and Death 7 weeks												
Approximate Interval Between Onset and Death 7 weeks												
Approximate Interval Between Onset and Death Years												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sepsis, Anemia, Gastrointestinal bleed, Portal Hypertension, Encephalopathy, Peptic ulcer disease, Abdominal abscess												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) M 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED		
29a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) At home		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Clinton Maryland										
29b. SIGNATURE AND TITLE OF CERTIFIER Tara T. Muscovitch MD		29c. LICENSE NUMBER D46992				29d. DATE SIGNED (Month, Day, Year) ► 5/31/95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Tara T. Muscovitch MD 14300 Gallant Fox Ln, Suite 118 Bowie, MD 20715												
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE Juli Shuler-Katell				DHMH-16 Rev 1/99						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

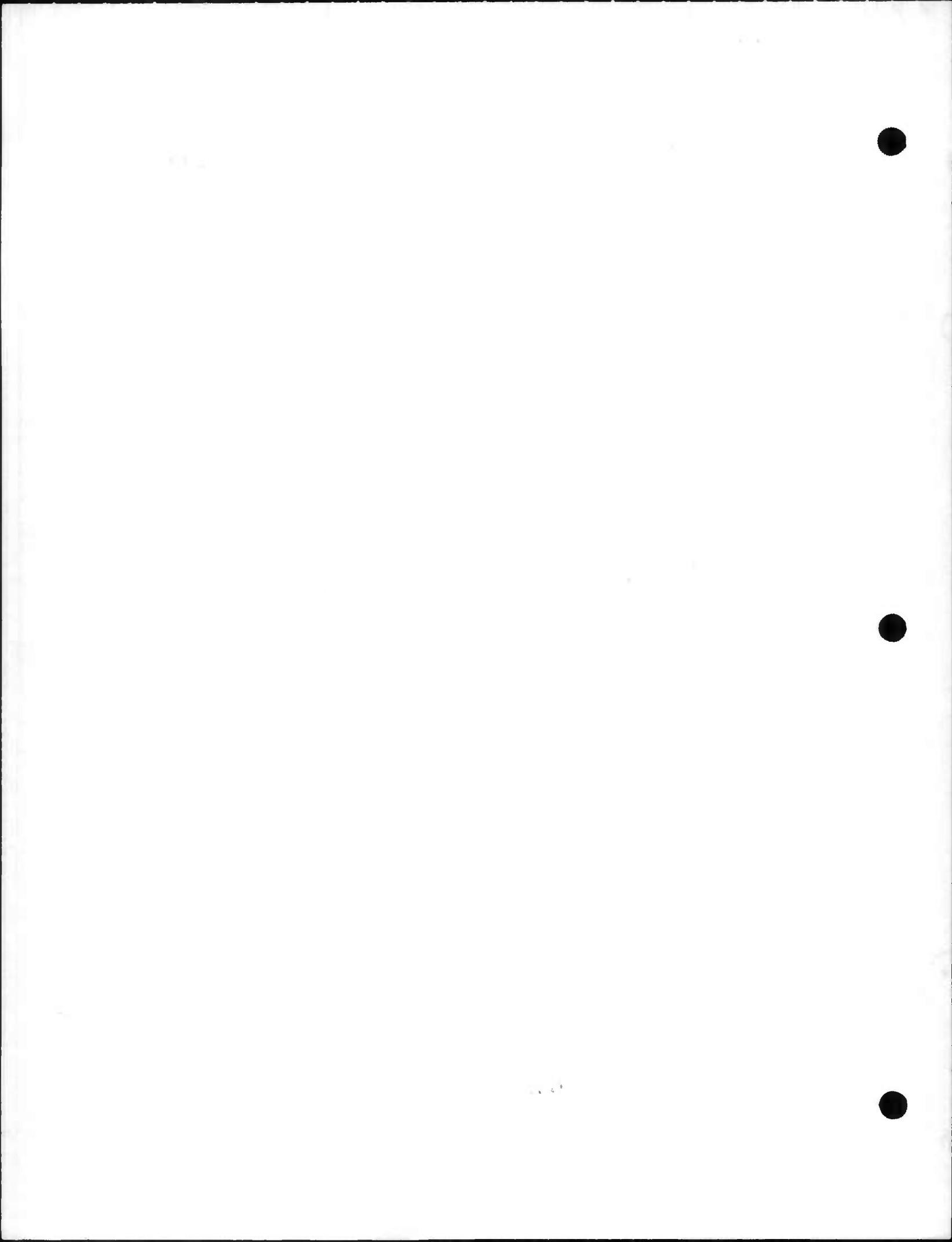
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) DORA MAE SLATTERY										2. DATE OF DEATH MONTH May DAY 31 YEAR 1995	3. TIME OF DEATH 12:30 P.M.
4. SOCIAL SECURITY NUMBER 577-34-3577		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	IF UNDER 24 HRS. MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN.	7. DATE OF BIRTH (Month, Day, Year) May 6, 1906	8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) 4309 74th Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Landover Hills			9c. COUNTY OF DEATH Prince George's				
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Landover Hills			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 4309 74th Avenue				10f. ZIP CODE 20784			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Retail Clerk			16b. KIND OF BUSINESS/INDUSTRY Retail						
17. FATHER'S NAME (First, Middle, Last) Joseph Brantly Boteler					18. MOTHER'S NAME (First, Middle, Maiden Surname) Lessie Mae Dorney						
19a. INFORMANT'S NAME (Type/Print) Joseph C. Slattery					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6901 St. Anne's Avenue, Lanham, Maryland 20706						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery 6/2/95			DATE	20c. LOCATION — City or Town, State Silver Spring, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Geise					22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death	
s. Hypertensive Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D21230								29d. DATE SIGNED (Month, Day, Year) JUNE 1, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez, M.D. 5009 Rayburn Court, Camp Springs, Maryland 20748											
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE John Shuler									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

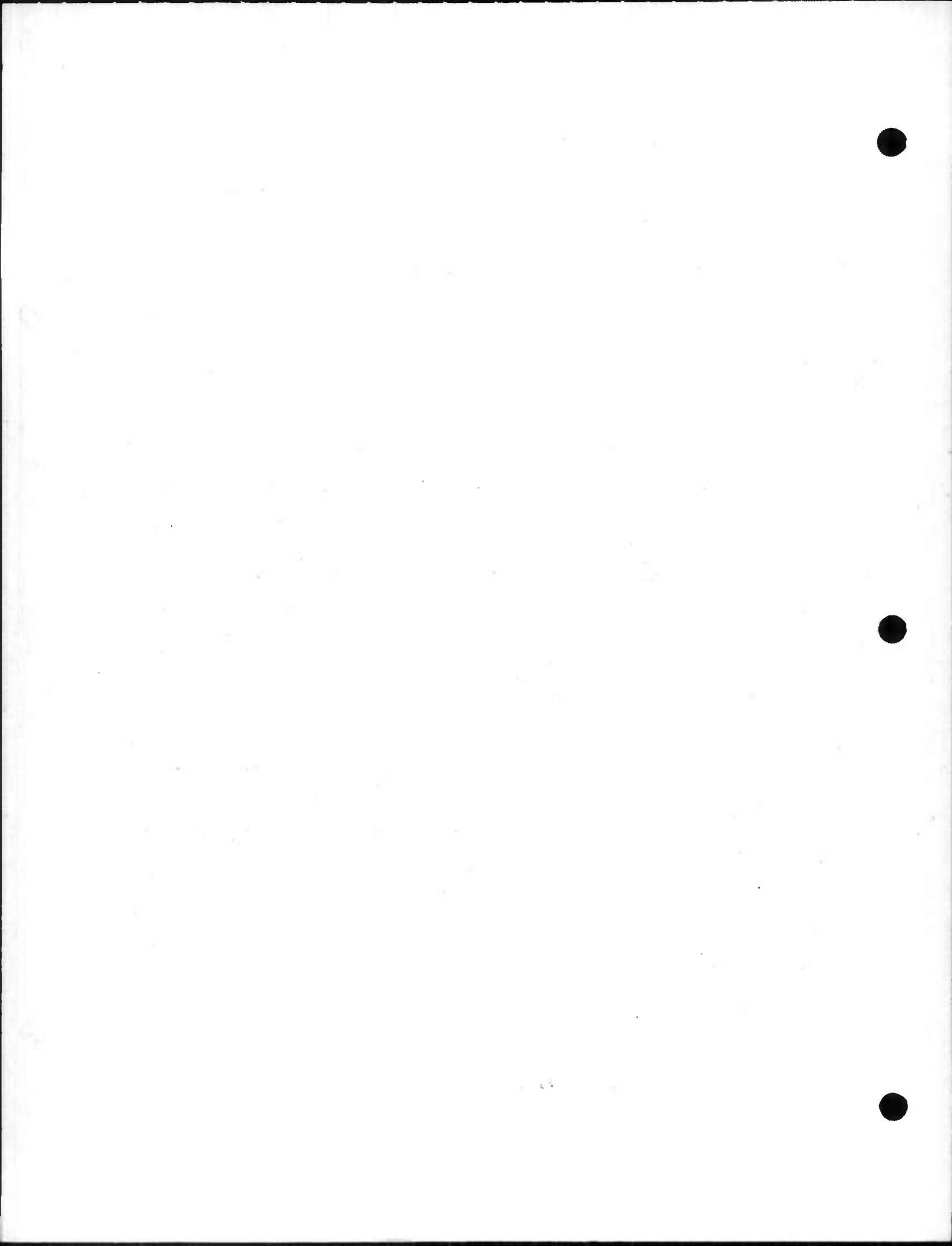
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR													
1. DECEASED'S NAME (First, Middle, Last) CATHERINE BOWEN SCOTT												2. DATE OF DEATH MONTH JUNE DAY 4, YEAR 1995	3. TIME OF DEATH 8:58 A M
4. SOCIAL SECURITY NUMBER 218-30-3960		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct. 29, 1907		8. BIRTHPLACE (State or Foreign Country) South Carolina			
9a. FACILITY NAME (If not institution, give street and number) Hillhaven Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Adelphi				9c. COUNTY OF DEATH Prince George's					
RESIDENCE OF DECEASED													
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION University Park				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 4326 Underwood Street				10f. ZIP CODE 20782				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home									
17. FATHER'S NAME (First, Middle, Last) Robert Edward Bowen				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Fennell Hughs									
19a. INFORMANT'S NAME (Type/Print) Leland E. Scott				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4326 Underwood Street, University Park, MD 20782									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Crematory				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6/6/95				20c. LOCATION — City or Town, State Alexandria, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Francis Gasch's Sons Funeral Home, P.A.				22. NAME AND ADDRESS OF FACILITY 4739 Baltimore Ave., Hyattsville, MD 20781									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bilateral Pneumonitis													
Approximate Interval Between Onset and Death Several days													
a. DUE TO (OR AS A CONSEQUENCE OF): Poisons Cerebrovascular Accident													
b. DUE TO (OR AS A CONSEQUENCE OF): LAST													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Arteriosclerotic Cardiovascular Disease													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D24593				29d. DATE SIGNED (Month, Day, Year) ► 6.5.95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mohammed Mannan, M.D. 3715 Rhode Island Avenue, Mount Rainier, Maryland 20712													
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRATION SIGNATURE Jahin								DHMH-10 Rev 1/99			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

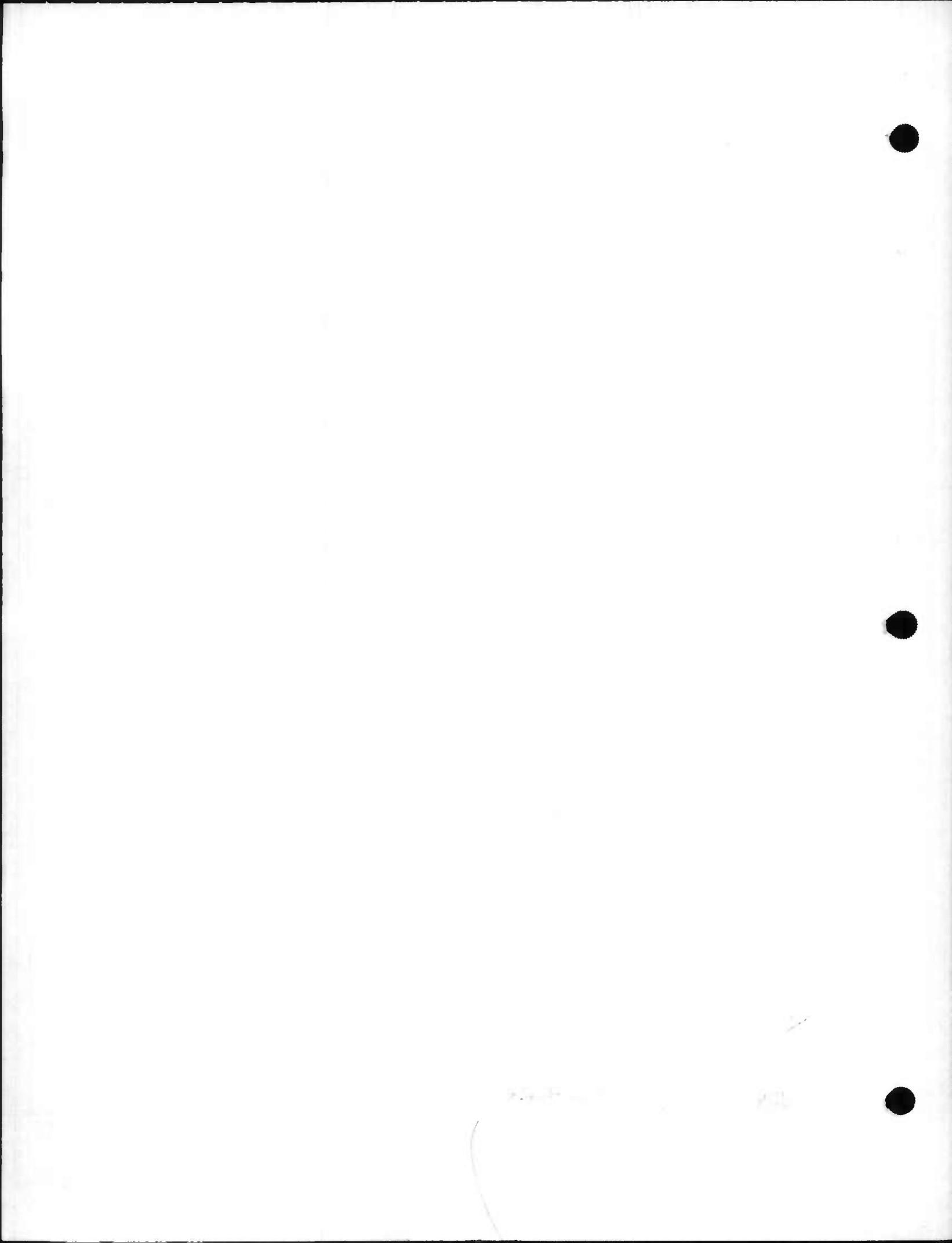
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19188

1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH MONTH DAY YEAR	
<i>FANNIE STALLINGS</i>		06 05 95 12:30P.M.					
4. SOCIAL SECURITY NUMBER 243-16-6900		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 90	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	8. BIRTHPLACE (State or Foreign Country) North Carolina	9. TIME OF DEATH Month, Day, Year Feb. 7, 1905	
9a. FACILITY NAME (If not institution, give street and number) Grosvenor Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Bethesda			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 5721 Grosvenor Lane			
10f. ZIP CODE 20814				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer		16b. KIND OF BUSINESS/INDUSTRY Private Industry			
17. FATHER'S NAME (First, Middle, Last) John Henry Knight				18. MOTHER'S NAME (First, Middle, Maiden Surname) Liz Knight			
19a. INFORMANT'S NAME (Type/Print) Willie Stallings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5011 11th St., NE, Washington, D.C., 20017			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pittman Grove Cemetery		DATE 6/10/95	20c. LOCATION — City or Town, State Battleboro, N.C.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.G. Jettus</i>		22. NAME AND ADDRESS OF FACILITY Frazier Funeral Home 389 Rhode Island Av., NW, Washington, D.C.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Uterine Cancer							
Approximate Interval Between Onset and Death							
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation, Congestive Heart Failure, Peripheral Vascular Disease, Renal Failure							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elliott Goldstein MD</i>				29c. LICENSE NUMBER D03581		29d. DATE SIGNED (Month, Day, Year) ► 6/6/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliott Goldstein, MD 5480 Wisconsin Ave., Chevy Chase, Md., Suite #LL5							
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE <i>John Dawson-Kordell</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

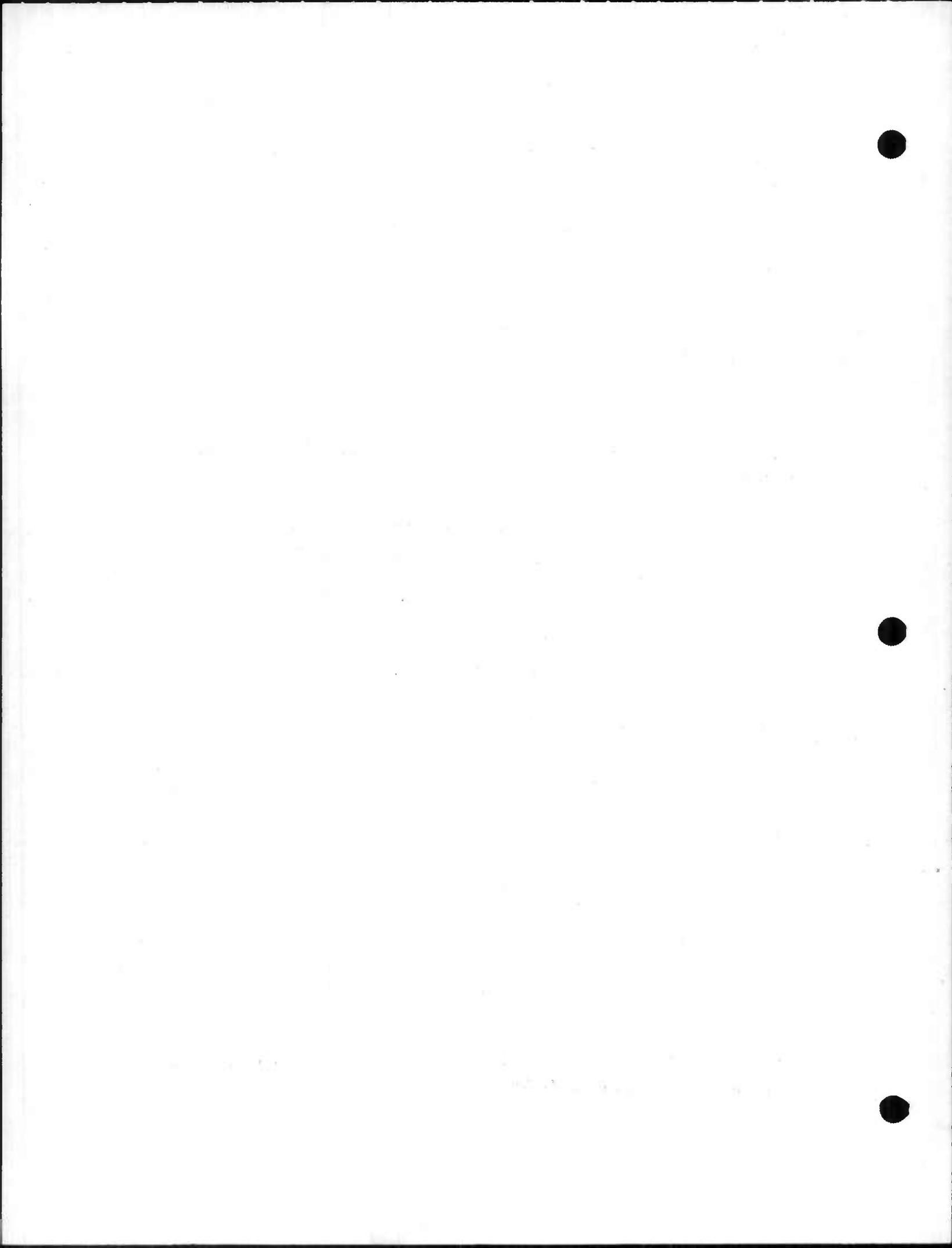
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) MARJORIE SOLOMAN												2. DATE OF DEATH MONTH DAY YEAR June 5, 1995	3. TIME OF DEATH 2:00 A.M.
4. SOCIAL SECURITY NUMBER 213-42-5421		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 53 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 MONTHS 0 DAYS 0 HOURS 0 MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 29, 1941	8. BIRTHPLACE (State or Foreign Country) Washington, DC							
9. FACILITY NAME (If not institution, give street and number) Golden Oaks Convalescent Center				9b. CITY, TOWN OR LOCATION OF DEATH Laurel			9c. COUNTY OF DEATH Prince George's						
RESIDENCE OF DECEASED													
10a. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Laurel						10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 9001 Cherry Lane				10f. ZIP CODE 20708			10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Dry Cleaner			16b. KIND OF BUSINESS/INDUSTRY Private								
17. FATHER'S NAME (First, Middle, Last) Sherman Eugene Moon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Stella Mary Mackenzie									
19a. INFORMANT'S NAME (Type/Print) Susie Yancey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 425 Jordan Drive, Tucker, Georgia 30084									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Floral Hills Memory Gardens			20c. LOCATION — City or Town, State 06/08/95 Tucker, Georgia						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
s. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):													
b. Parkinson's Disease (End Stage) DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 25422											
29d. DATE SIGNED (Month, Day, Year) ► 6/5/95													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Maggin, M.D. 14333 Laurel-Bowie Road, #307, Laurel, Maryland 20708-1160													
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE 											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

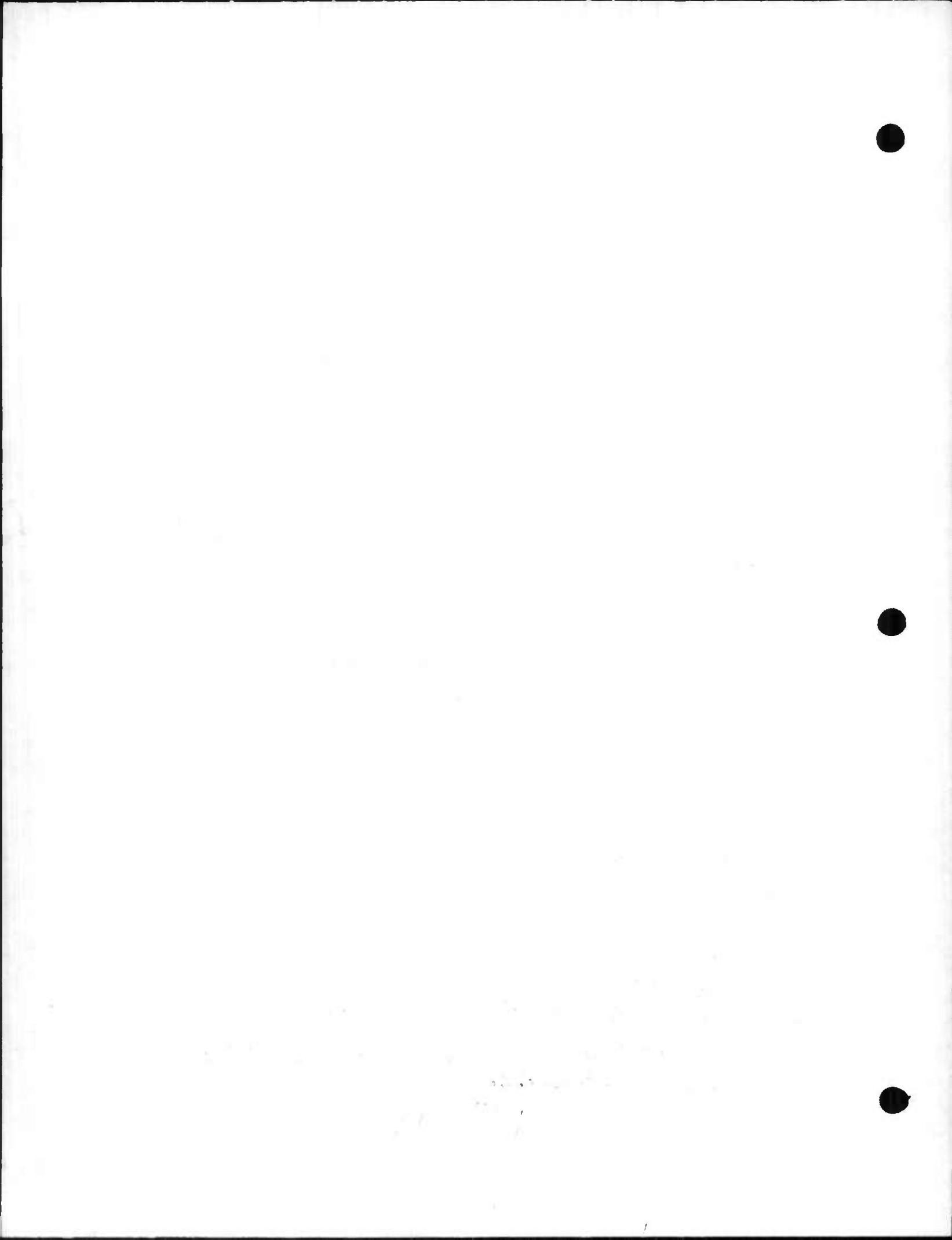
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		MAZIE BELL SANDLE						2. DATE OF DEATH MONTH <u>MAY</u> DAY <u>31</u> YEAR <u>1995</u>		3. TIME OF DEATH <u>9:00 A.M.</u>	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) <u>4-29-00</u>		8. BIRTHPLACE (State or Foreign Country) <u>Suitland Md.</u>	
578-22-7187		<input type="checkbox"/> M <input checked="" type="checkbox"/> F	95 YRS.	MONTHS	DAYS	HOURS	MIN.				
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Holy Cross Hospital				Silver Spring				Montgomery			
RESIDENCE OF DECEASED											
10a. STATE <u>D. C.</u>	10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Washington</u>								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <u>1200 Van Buren Street, N. W.</u>				10f. ZIP CODE <u>20012</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12th</u>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Clerk</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Navy Department</u>			
17. FATHER'S NAME (First, Middle, Last) <u>James R. Carroll</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hattie Brooks</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Henry Brooks Shepard</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>20 Underwood Street NE Washington DC 20012</u>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>Maryland National Memorial</u>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>16-7 Laurel Md.</u>				DATE	20c. LOCATION — City or Town, State <u>4217 9th Street, N. W. Washington, D. C. 20011</u>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>J P Marshall</u>				22. NAME AND ADDRESS OF FACILITY <u>Marshall's Funeral Home Inc</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
<p><i>sepsis</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small></p> <p><i>multiply decubitus ulcers</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small></p> <p><i>organic brain syndrome</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small></p>											
Approximate Interval Between Onset and Death											
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>WALTER E. GOONHAY</u>				29c. LICENSE NUMBER <u>P01120</u>				29d. DATE SIGNED (Month, Day, Year) <u>1 June 95</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>WALTER E. GOONHAY 9309 SHOREFIELD RD WHEATON MD 20902</u>											
31. DATE FILED (Month, Day, Year) <u>JUN 06 1995</u>				32. REGISTRAR'S SIGNATURE <u>John Michael Parker</u>							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

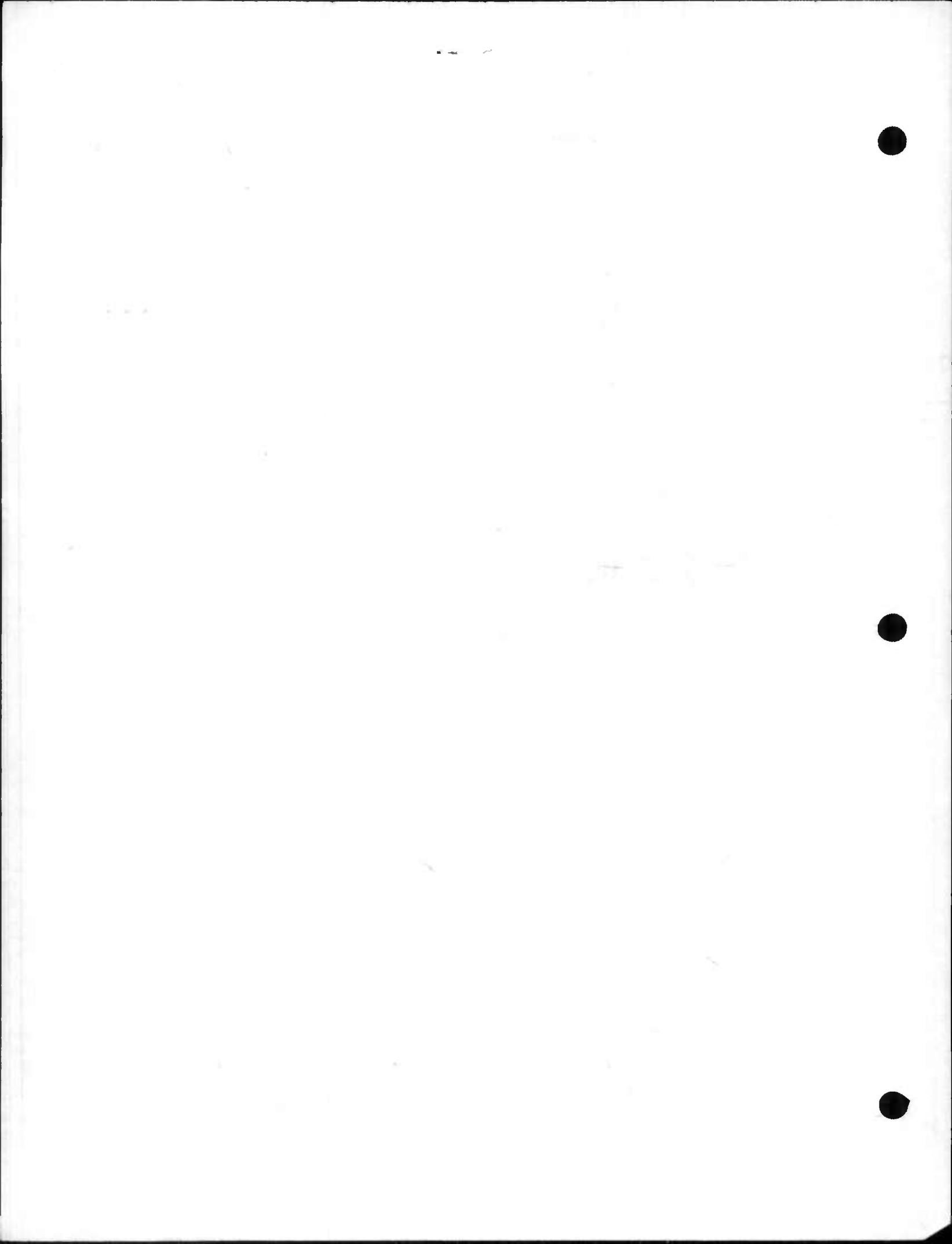
ITEM: 1. PER F.H. FILM G-729 11/22/95 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19191

1. DECEDENT'S NAME (First, Middle, Last) Hilda Esther ESTHER Sain				2. DATE OF DEATH MONTH JUNE DAY 4 YEAR 1995	3. TIME OF DEATH 6:14 AM	
4. SOCIAL SECURITY NUMBER 579-20-8279		5. SEX M	6. AGE (In yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1903	8. BIRTHPLACE (State or Foreign Country) Virginia
9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH LaPlata		9c. COUNTY OF DEATH Charles
RESIDENCE OF DECEDENT						
10a. STATE Maryland	10b. COUNTY Charles	10c. CITY, TOWN OR LOCATION Waldorf				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 86 Garner Avenue				10f. ZIP CODE 20602		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. Specify: Caucasian
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cafeteria Supervisor			16b. KIND OF BUSINESS/INDUSTRY Geico Insurance	
17. FATHER'S NAME (First, Middle, Last) Michael Kelley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Cooper		
19a. INFORMANT'S NAME (Type/Print) Gloria Sain				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 86 Garner Avenue Waldorf, Maryland 20602		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Ft. Lincoln Cemetery 1995			20c. LOCATION — City or Town, State Brentwood, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► H. S. Sitt				22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20725		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arrhythmia (Asystole) DUE TO (OR AS A CONSEQUENCE OF):						
Approximate Interval Between Onset and Death 60 Min						
b. Atherosclerotic Cardio Vascular Disease DUE TO (OR AS A CONSEQUENCE OF):						
Years						
c. DUE TO (OR AS A CONSEQUENCE OF):						
d. DUE TO (OR AS A CONSEQUENCE OF):						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. H/O Myocardial Infarction						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A	28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? N/A	28d. DESCRIBE HOW INJURY OCCURRED N/A	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER ► Dr. Ashvinkumar Patel				29c. LICENSE NUMBER D44436		29d. DATE SIGNED (Month, Day, Year) ► 6/4/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ashvinkumar Patel, MD 603 Post Office Rd. Suite 207 Waldorf, Md 20602						
31. DATE FILED (Month, Day, Year) JUN 13 1995	32. REGISTRAR'S SIGNATURE Jahn Anderson-Ravell					DHMH-16 Rev 1/90



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

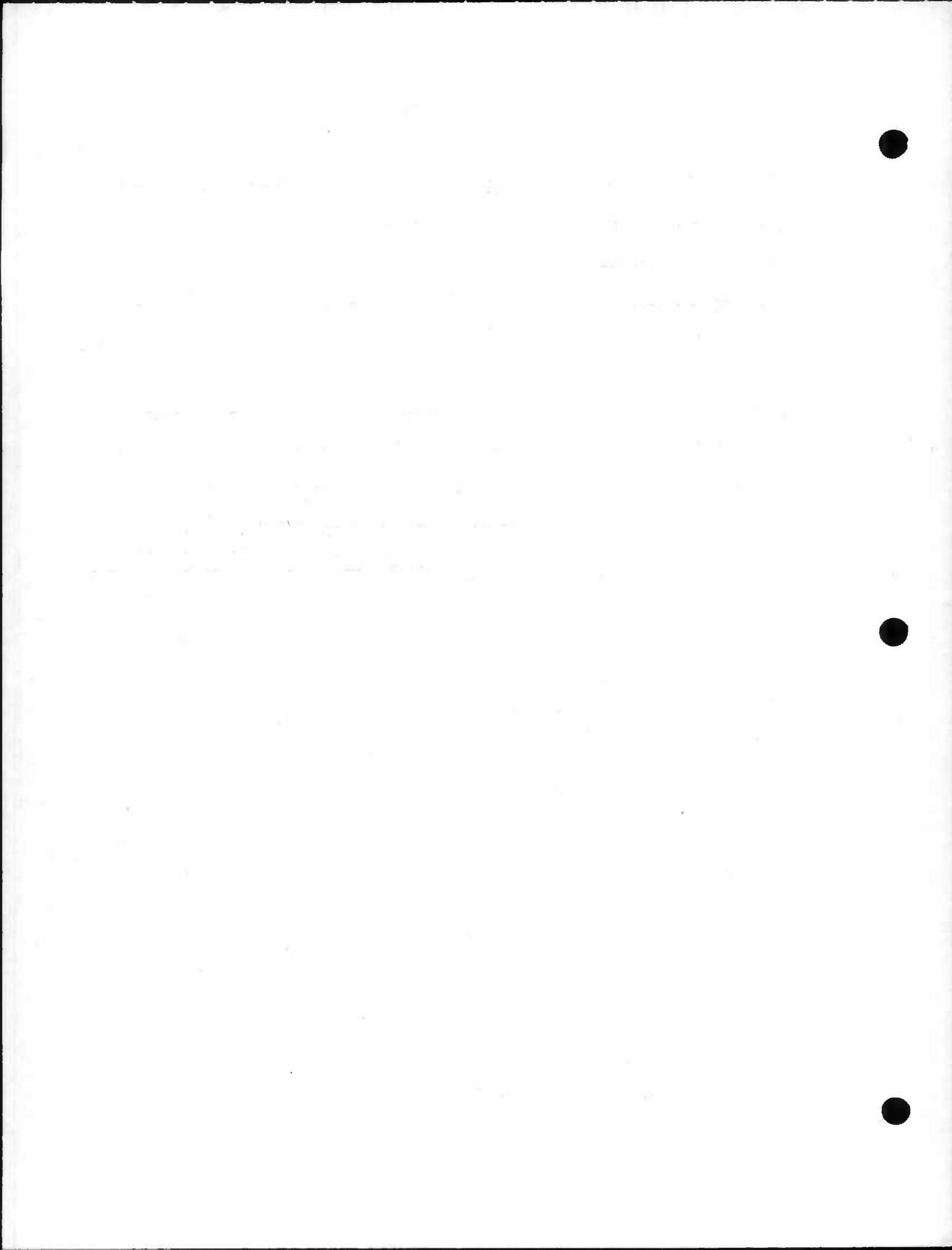
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19192

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH JUNE 8, 1995 DAY YEAR 02:54	3. TIME OF DEATH 02:54 M
CHARLES SUTTON						7. DATE OF BIRTH (Month, Day, Year) April 24, 1951	
4. SOCIAL SECURITY NUMBER 220-62-9772		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) CALVERT MEMORIAL HOSPITAL RESIDENCE OF DECEDED						9b. CITY, TOWN OR LOCATION OF DEATH PRINCE FREDERICK	
10a. STATE Maryland	10b. COUNTY Calvert	10c. CITY, TOWN OR LOCATION Lusby				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 960 Olivet Road				10f. ZIP CODE 20657		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 8+) Plasterer		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) William Sutton				18. MOTHER'S NAME (First, Middle, Maiden Surname) Loretta Smith			
19e. INFORMANT'S NAME (Type/Print) Thelma Sutton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 130 Lusby, MD 20657			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Church Cemetery		DATE 6/13/95	20c. LOCATION — City or Town, State Lusby, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Sewell Funeral Home 1451 Dares Beach Rd. Prince Frederick, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Cryptococcal meningitis and disseminated cryptococcosis</i> DUE TO (OR AS A CONSEQUENCE OF)</p> <p>b. <i>Acquired Immunodeficiency syndrome</i> DUE TO (OR AS A CONSEQUENCE OF)</p> <p>c. <i>Intravenous drug abuse</i> DUE TO (OR AS A CONSEQUENCE OF)</p> <p>d.</p>							
Approximate Interval Between Onset and Death 5 months 2 years 15 years							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cytomegalovirus retinitis</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Paul Pomilla,				29c. LICENSE NUMBER D 46314		29d. DATE SIGNED (Month, Day, Year) ► 6/9/95	
31. DATE FILED (Month, Day, Year) JUN 13 1995				32. REGISTRAR'S SIGNATURE 			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

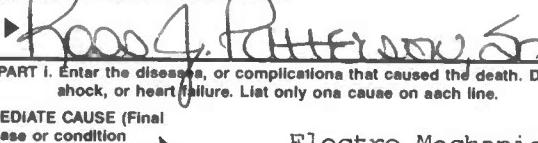
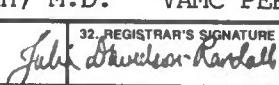
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRAR

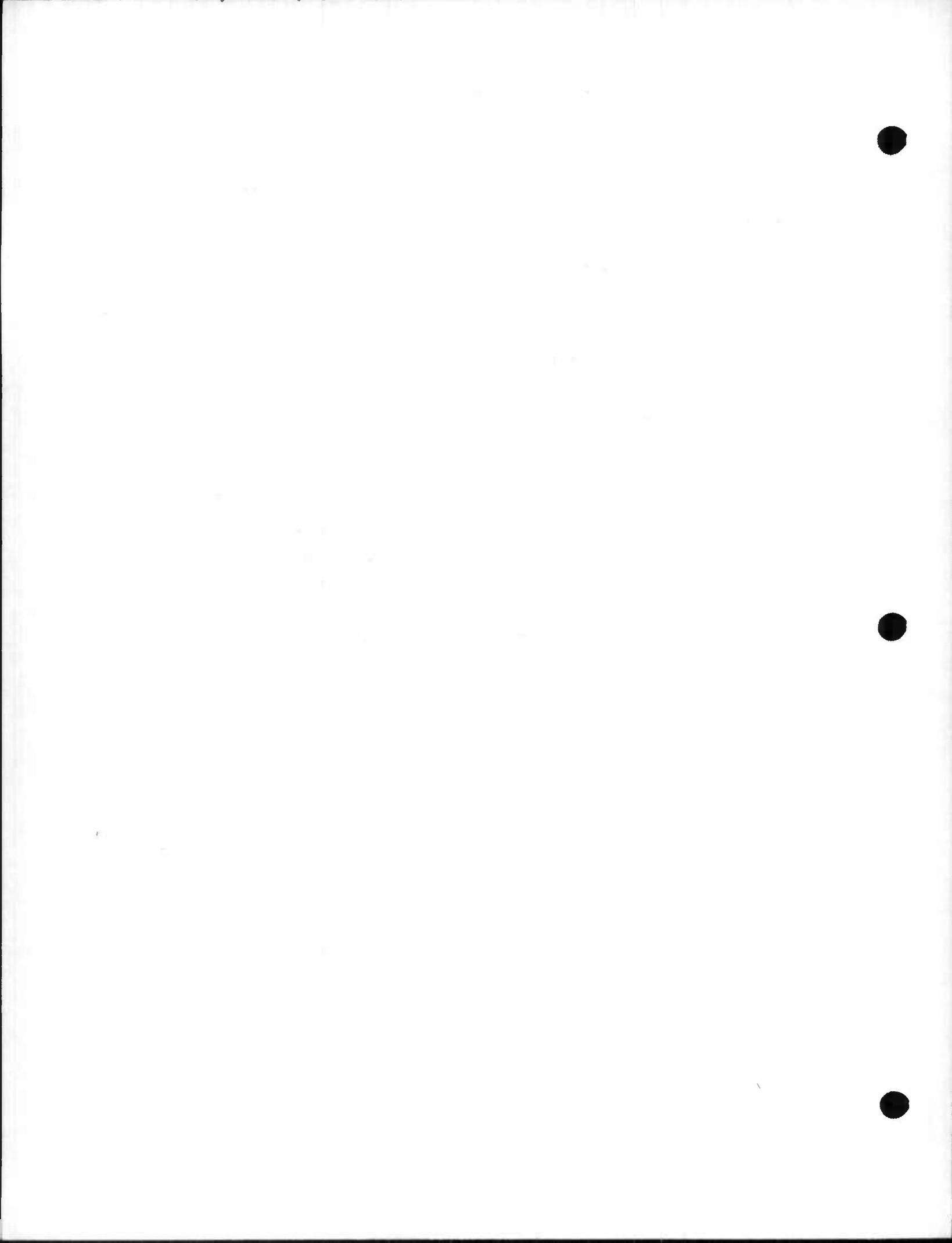
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19193

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
Phillip T. Smith						June 07 1995	5:14A M		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
250-52-6864		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	70 YRS.	MONTHS	DAYS	HOURS	MIN.	Oct. 10, 1924	South Carolina
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
V.A. Medical Center						Perry Point		Cecil	
RESIDENCE OF DECEDENT									
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
Maryland	Cecil		Colora						
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?	
1574 Colora Road				21917				U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Ten Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Laborer				16b. KIND OF BUSINESS/INDUSTRY Steel Company			
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Allfair Smith						Annie Jennings			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
William Smith				100 Harlan Drive, Coatesville, Pennsylvania 19320					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mellinger's Mennonite Cem.				DATE	20c. LOCATION — City or Town, State Lancaster, PA		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Electro Mechanical Dissociation DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE NOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER MD#D32395							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		29d. DATE SIGNED (Month, Day, Year) ► 06/07/95							
Thomas Finucan, M.D. VAMC PERRY POINT, MD 21902									
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

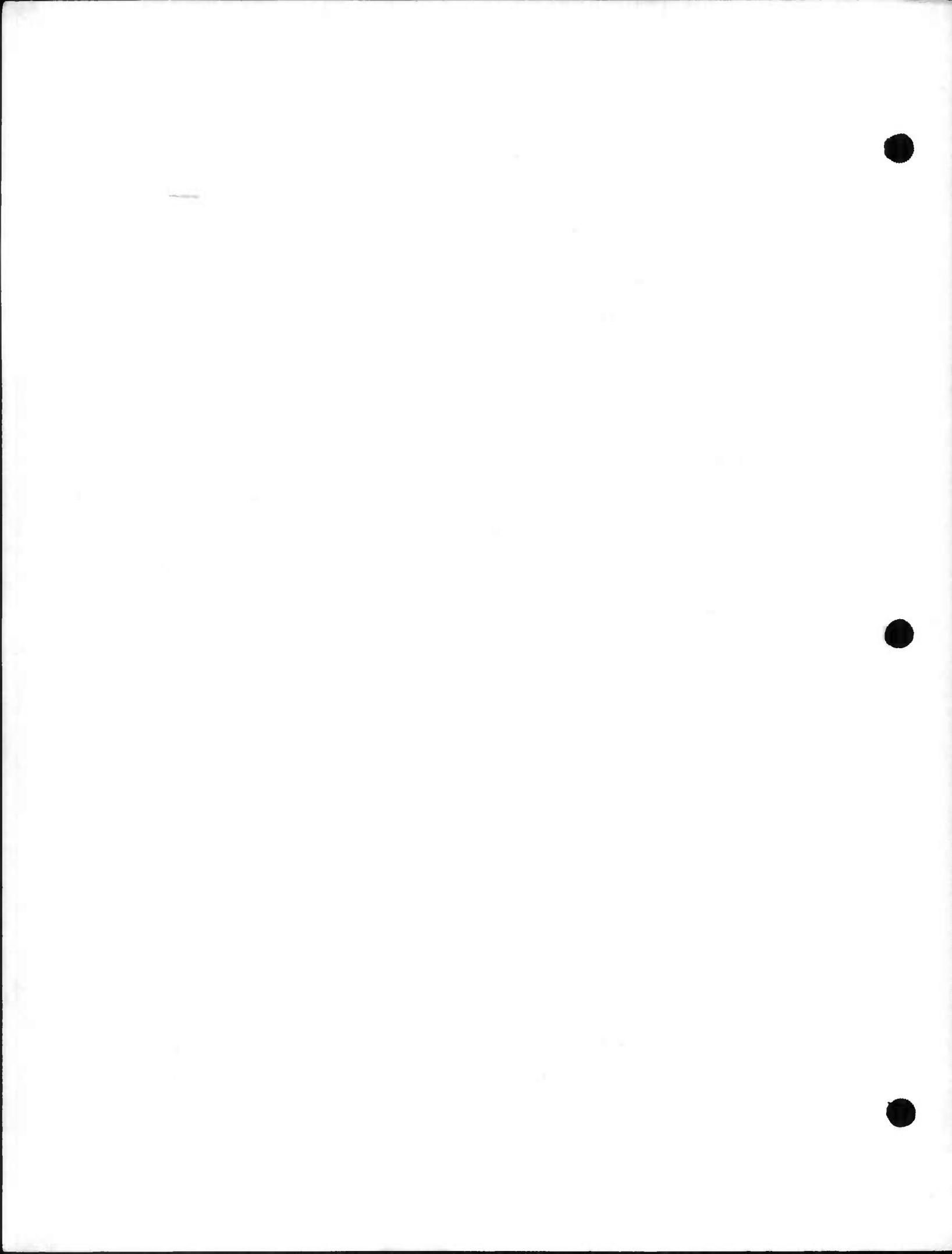
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH June		DAY 9	YEAR 1995	3. TIME OF DEATH 0056
		MARTHA MARY VIRGINIA SIER									
4. SOCIAL SECURITY NUMBER 212-24-7273		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 21, 1920	8. BIRTHPLACE (State or Foreign Country) Maryland		
9e. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick							9c. COUNTY OF DEATH Frederick		
10e. STATE Maryland		10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Ijamsville							10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9729 Reichs Ford Road		10f. ZIP CODE 21754							10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 years		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Dietician			16b. KIND OF BUSINESS/INDUSTRY None						
17. FATHER'S NAME (First, Middle, Last) Charles Hahn		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary King									
19e. INFORMANT'S NAME (Type/Print) Norman F. Sier		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9729 Reichs Ford Road Ijamsville, Maryland 21754									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery			DATE 6/12	20c. LOCATION — City or Town, State Frederick, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Dailey</i>		22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701									
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death immediate	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Myocardial infarction</i> b. _____ c. _____ d. _____ Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Timothy F. Hickey MD Parkview Medical Center Frederick, Maryland 21701		29c. LICENSE NUMBER DO 1711							29d. DATE SIGNED (Month, Day, Year) ► 6/9/95		
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE <i>John Anderson, R.R.C.L.</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

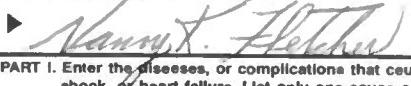
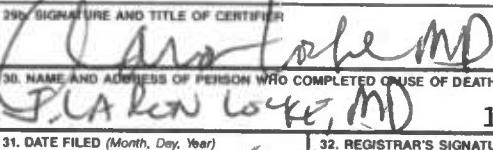
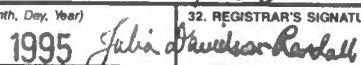
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

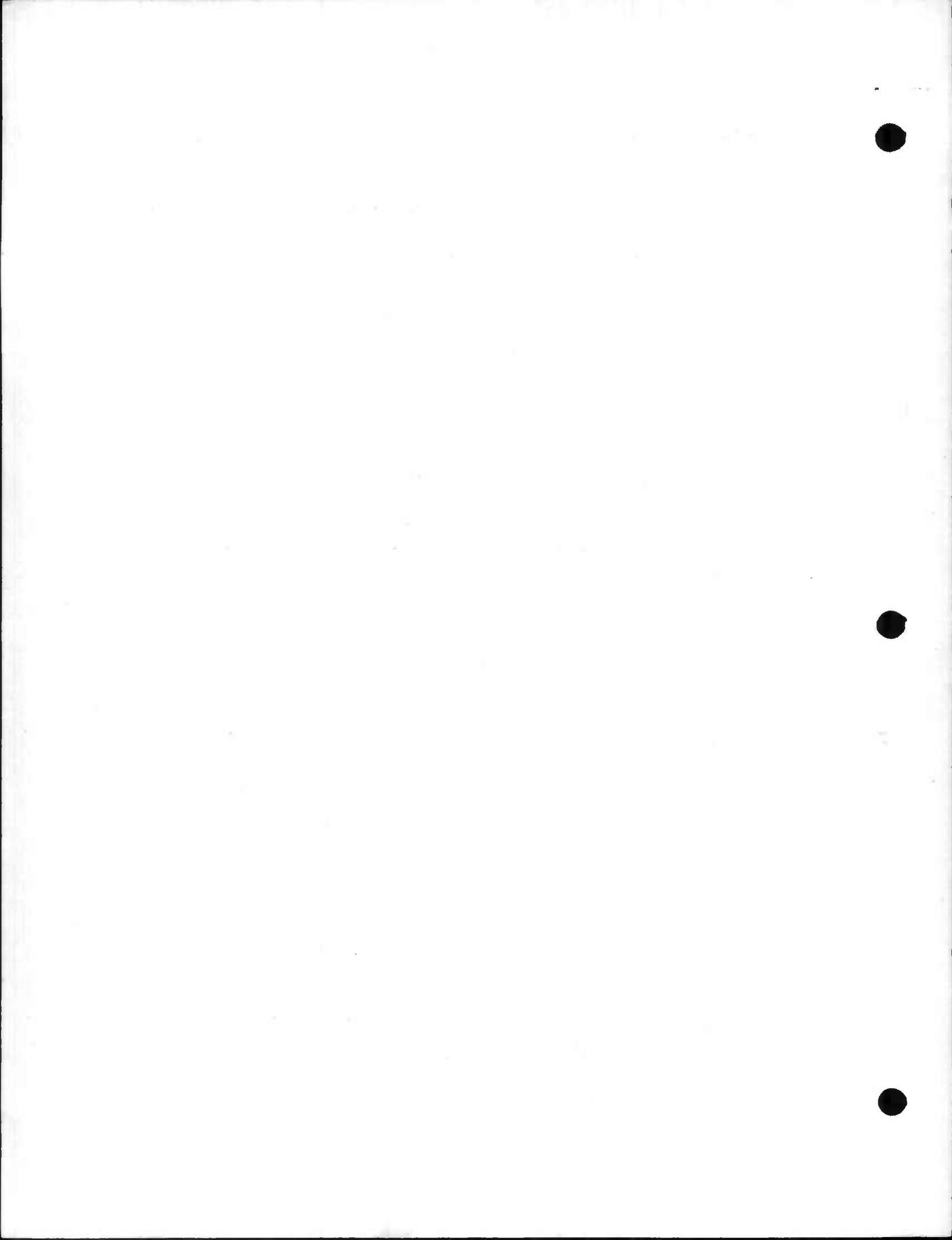
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 95 19195			
1. DECEDENT'S NAME (First, Middle, Last) MICHAEL ANDREW SHIPLEY												2. DATE OF DEATH MONTH JUNE DAY 09 YEAR 1995		3. TIME OF DEATH 10:55 P.M.	
4. SOCIAL SECURITY NUMBER 218-54-2829		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 21, 1955		8. BIRTHPLACE (State or Foreign Country) Carroll			
9a. FACILITY NAME (If not institution, give street and number) CARROLL COUNTY HOSPITAL												9b. CITY, TOWN OR LOCATION OF DEATH WESTMINSTER		9c. COUNTY OF DEATH CARROLL	
10e. STREET AND NUMBER 97 Carroll View Avenue		10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Westminster		10f. ZIP CODE 21157		10g. CITIZEN OF WHAT COUNTRY? U.S.A.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army - Vietnam		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Repairman		16b. KIND OF BUSINESS/INDUSTRY Office Machines											
17. FATHER'S NAME (First, Middle, Last) Lester C. Shipley Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Della Marie Garrison													
19e. INFORMANT'S NAME (Type/Print) Tammy Lee Shipley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 97 Carroll View Ave, Westminster, Md. 21157													
20e. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Carroll Cremation Serv.		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6/12 Hampstead, Md.		DATE		20c. LOCATION — City or Town, State									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY FLETCHER FUNERAL HOME 254 E. Main St. Westminster, Md. 21157													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC INTOXICATION															
a. DUE TO (OR AS A CONSEQUENCE OF):															
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)		OTHER: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26d. DESCRIBE HOW INJURY OCCURED UNKNOWN		24c. LOCATION (Street and Number or Rural Route Number, City or Town, State) 21 W. GREEN ST. WESTMINSTER, MD.							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year) 6-9-95		26b. TIME OF INJURY UNKNOWN		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME													
29a. CERTIFYING PHYSICIAN (Check only one)		1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
		2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) JUNE 11, 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PLA Ron Locke, MD		31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE 											



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

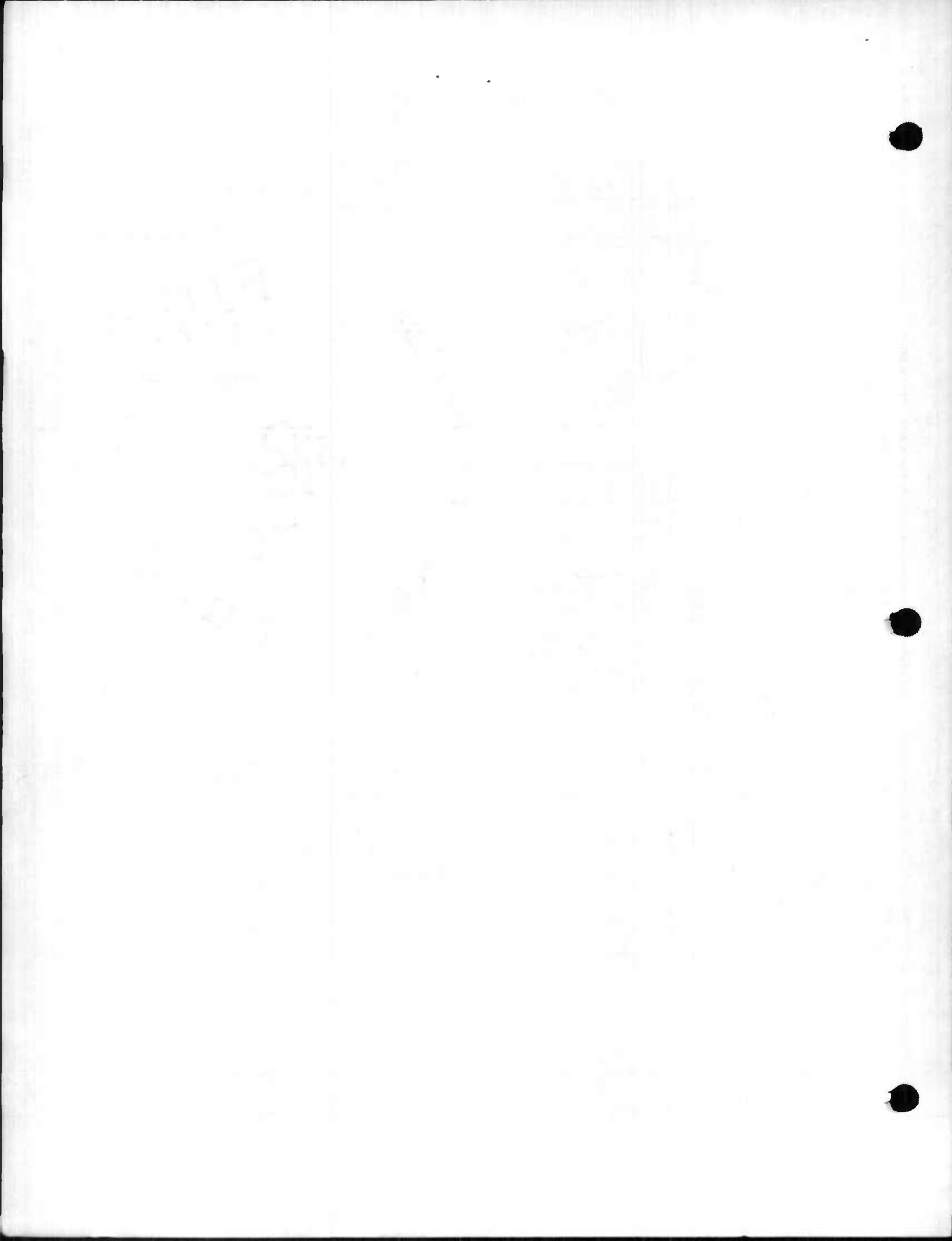
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Marie Hash Sorrell										2. DATE OF DEATH MONTH JUNE DAY 06 YEAR 1995	3. TIME OF DEATH 12:20 P M	
4. SOCIAL SECURITY NUMBER 577-05-4155		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 08-29-1901	8. BIRTHPLACE (State or Foreign Country) Virginia	
9a. FACILITY NAME (If not institution, give street and number) Hartley Hall Nursing Home										9b. CITY, TOWN OR LOCATION OF DEATH Pocomoke City	9c. COUNTY OF DEATH Worcester	
RESIDENCE OF DECEDENT												
10a. STATE MD	10b. COUNTY Worcester		10c. CITY, TOWN OR LOCATION Pocomoke City						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1006 Market St.				10f. ZIP CODE 21851			10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ret. Hotel Housekeeper				16b. KIND OF BUSINESS/INDUSTRY Hotel				
17. FATHER'S NAME (First, Middle, Last) John A. Hash						18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah E. Long						
19a. INFORMANT'S NAME (Type/Print) Billie D. Saunders				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7570 Pocomoke River Rd, Pocomoke City, MD 21851								
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Comfort Cemetery				20c. LOCATION — City or Town, State 6/9/95 Alexandria VA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James N. Fox				22. NAME AND ADDRESS OF FACILITY Fox Funeral Home Perry Avenue, VA 23442								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Advanced Dementia												
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. Advanced Alzheimer's Disease												
c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):												
Approximate Interval Between Onset and Death 4 yrs												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Fracture. Blindness. Deafness. Anemia. Intertrochanteric Fracture left hip												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D29505										
29b. SIGNATURE AND TITLE OF CERTIFIER Gregorio M. Belloso M.D.		29d. DATE SIGNED (Month, Day, Year) ► 6-6-95										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GREGORIO M. BELLISO, M.D. 4421 BEECHWOOD PL., CRISFIELD MD 21817												
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE John D. Johnson, R.R. 1										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

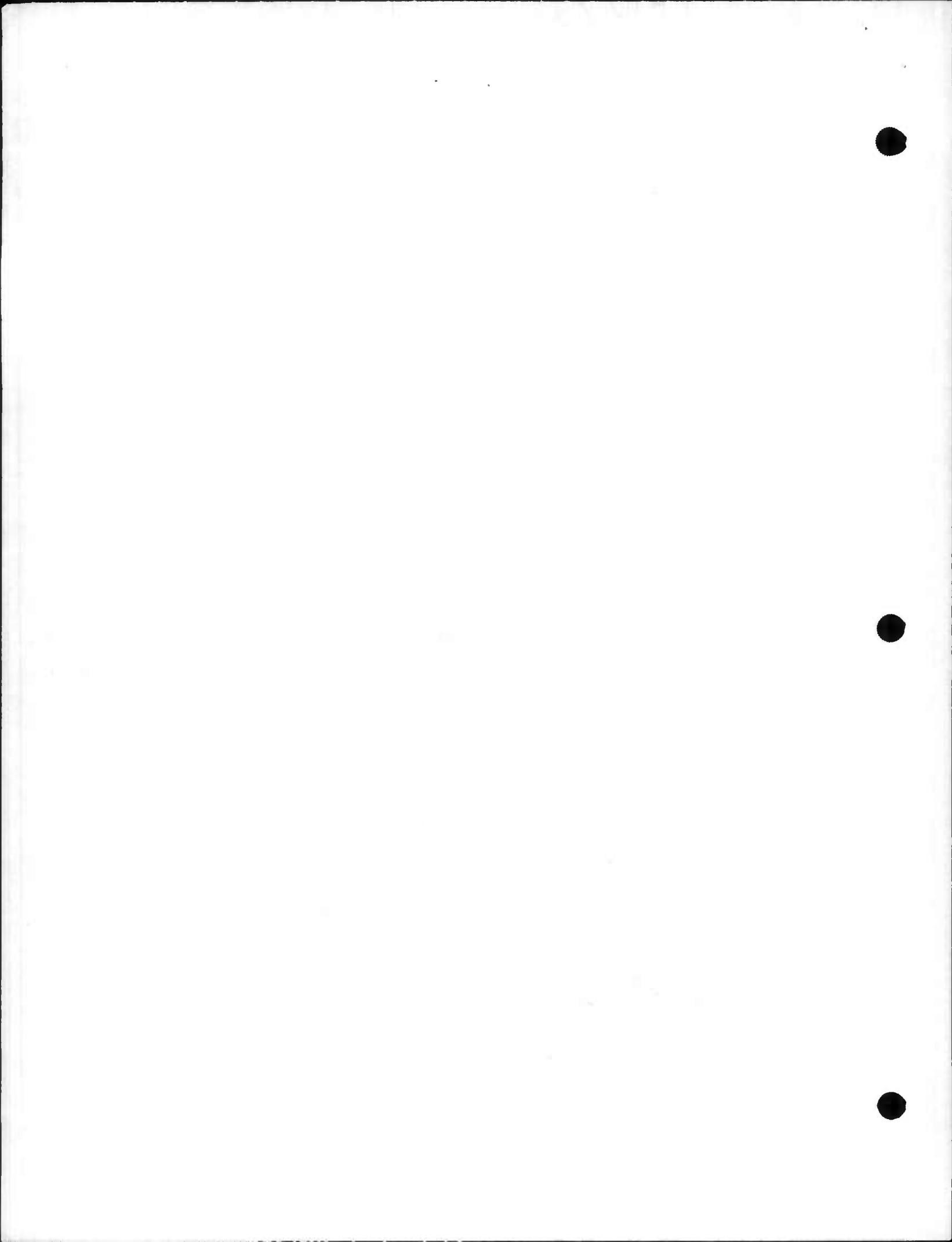
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Jasper Sawyer										2. DATE OF DEATH MONTH June DAY 10 YEAR 1995	3. TIME OF DEATH 1200	
4. SOCIAL SECURITY NUMBER 240-32-6418			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS 2 DAYS 12		IF UNDER 24 HRS. HOURS 30 MIN. 00		7. DATE OF BIRTH (Month, Day, Year) 2-12-30	8. BIRTHPLACE (State or Foreign Country) NC		
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER										9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT												
10a. STATE VA	10b. COUNTY Accomack	10c. CITY, TOWN OR LOCATION Saxis								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER PO Box 162					10f. ZIP CODE 23427				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Disabled Vet			18b. KIND OF BUSINESS/INDUSTRY Military (Ret)						
17. FATHER'S NAME (First, Middle, Last) Unknown					18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown							
19a. INFORMANT'S NAME (Type/Print) Burley Martin					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Saxis VA 23427							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Downings Cemetery			DATE 6/12	20c. LOCATION — City or Town, State Oak Hall, VA			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE D James N. Fox					22. NAME AND ADDRESS OF FACILITY Fox Funeral Home, PO Box 278 Temperanceville, VA 23442							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CEREBRAL VASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF):										1 WEEK		
b. Atherosclerotic Vessel Disease YEARS DUE TO (OR AS A CONSEQUENCE OF):												
c. DUE TO (OR AS A CONSEQUENCE OF):												
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. COPD										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Ronald P. Travitz MD										29c. LICENSE NUMBER D36576	29d. DATE SIGNED (Month, Day, Year) 6/10/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ronald P. Travitz MD										SALISBURY MD 21801		
31. DATE FILED (Month, Day, Year) JUN 12 1995			32. REGISTRAR'S SIGNATURE Linda S. Johnson-Randall									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

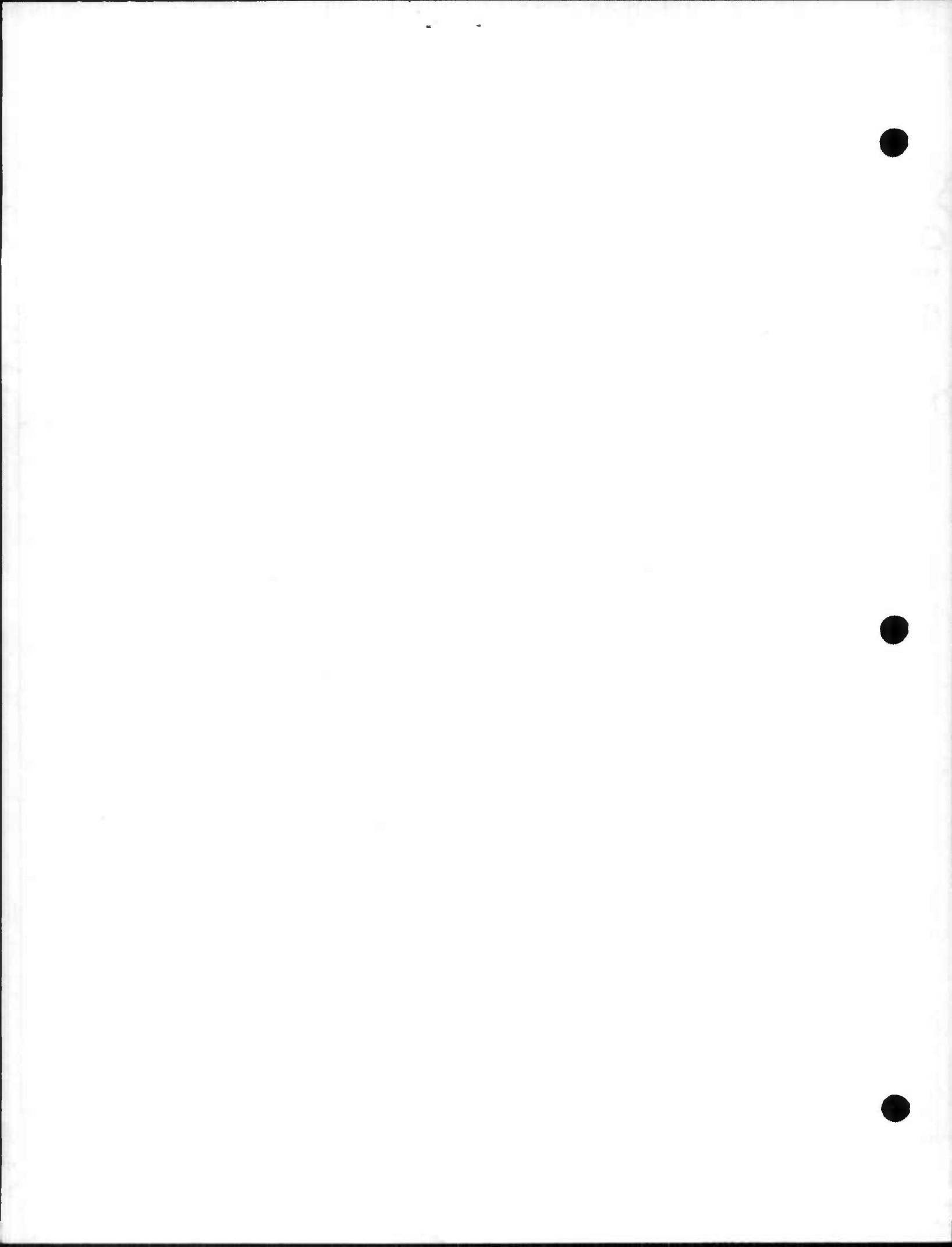
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FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19198

1. DECEDENT'S NAME (First, Middle, Last) Rebecca Gertrude Stonestreet						2. DATE OF DEATH MONTH DAY YEAR June 16 1995	3. TIME OF DEATH 1:00 p. m.
4. SOCIAL SECURITY NUMBER 232-66-1520D		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 yrs.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) 3-3-1901	8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Garrett County Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Oakland	9c. COUNTY OF DEATH Garrett
RESIDENCE OF DECEDENT							
10a. STATE W. Va.	10b. COUNTY Preston	10c. CITY, TOWN OR LOCATION Terra Alta				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 111 Adair St.				10f. ZIP CODE 26764		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) School Teacher			16b. KIND OF BUSINESS/INDUSTRY Elementary School		
17. FATHER'S NAME (First, Middle, Last) Perry Morgan Meadows				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Margaret Meadows			
19a. INFORMANT'S NAME (Type/Print) Dorothy F. Cale				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 First St. Terra Alta, WV 26764			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Arthur H. Wright		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Terra Alta Cemetery			DATE 6-19-95	20c. LOCATION — City or Town, State Terra Alta, WV 26764	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Arthur H. Wright				22. NAME AND ADDRESS OF FACILITY Arthur H. Wright Funeral Home, Inc. 105 Highland Ave. Terra Alta, WV 26764			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Stroke DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							
Approximate Interval Between Onset and Death 6 hours							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert M. Coughlin, M.D.				29c. LICENSE NUMBER D33464		29d. DATE SIGNED (Month, Day, Year) 6/17/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert M. Coughlin, M.D. P.O. Box 8 Egleton, WV 26716							
31. DATE FILED (Month, Day, Year) JUN 20 1995		32. REGISTRAR'S SIGNATURE Laura Jackson-Randall					



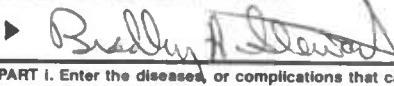
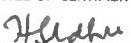
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)															
BETTY CAROLYN TUREK															
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.		2. DATE OF DEATH		3. TIME OF DEATH			
054-16-3210		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		74 YRS.		MONTHS		DAYS		MONTH DAY YEAR		23:15 M			
9a. FACILITY NAME (If not institution, give street and number)												9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
SACRED HEART HOSPITAL												CUMBERLAND		ALLEGANY	
RESIDENCE OF DECEASED															
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?			
NY	COLUMBIA			HUDSON								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER												10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
505 PROSPECT ST.												12534		USA	
11. MARITAL STATUS			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. RACE — American Indian, Black, White, etc. Specify:						
<input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married			IF YES, GIVE WAR OR OATES			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			WHITE						
3 <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced															
16. DECEASED'S EDUCATION (Specify only highest grade completed)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)					16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12) 11				College (1-4 or 5+) COLLEGE					HOME						
17. FATHER'S NAME (First, Middle, Last)												18. MOTHER'S NAME (First, Middle, Maiden Surname)			
HAROLD C. BELKNAP, SR.												FLORENCE — BURCH			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
LINDA J. ZLOMEK				11702 VALE SUMMIT RD., FROSTBURG, MD 21532											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)								DATE			
<input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				CEDAR PARK CEMETERY								6/7			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE												22. NAME AND ADDRESS OF FACILITY			
												STEWART FUNERAL HOME 32 S. 2ND. ST., OAKLAND, MD 21550			
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												1 week			
a. SEPTIC SHOCK												1 week			
b. SMALL & LAR GE BOWL INFARCTION												UNKNOWN			
c. ARTERIAL ATHEROSCLEROSIS															
d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
Chronic obstructive Lung Disease PERIPHERAL VASCULAR DISEASE												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)											
HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide															
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)												28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 												29c. LICENSE NUMBER D26907			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												29d. DATE SIGNED (Month, Day, Year) JUNE 5, 1995			
DR. HARJIT SIDHU, M.D., 925 BISHOP WALSH ROAD, CUMBERLAND, MD 21502				31. DATE FILED (Month, Day, Year) JUN 05 1995								32. REGISTRAR'S SIGNATURE 			

6 x 10 mm

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TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		MILDRED CATHERINE TREGO					2. DATE OF DEATH MONTH JUNE DAY 9, 1995 YEAR		3. TIME OF DEATH 5:23 P M		
4. SOCIAL SECURITY NUMBER 220-16-9200		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		7. DATE OF BIRTH (Month, Day, Year) DEC. 21, 1904	
8a. FACILITY NAME (If not institution, give street and number) GLASGOW NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH CAMBRIDGE					8c. COUNTY OF DEATH DORCHESTER		8. BIRTHPLACE (State or Foreign Country) MARYLAND		
RESIDENCE OF DECEDENT		10a. STATE MARYLAND		10b. COUNTY DORCHESTER		10c. CITY, TOWN OR LOCATION SECRETARY			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 109 ACADEMY STREET							10f. ZIP CODE 21664		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES					13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)					16b. KIND OF BUSINESS/INDUSTRY SEAMSTRESS GARMENT FACTORY				
17. FATHER'S NAME (First, Middle, Last) THOMAS ALVA COLBOURN							18. MOTHER'S NAME (First, Middle, Maiden Surname) CARRIE REBECCA MOORE				
19a. INFORMANT'S NAME (Type/Print) MELVIN TREGO		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 TALISMAN LANE, CAMBRIDGE, MD 21613									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, temporary or other place) DORCHESTER MEMORIAL PARK					DATE 6/12		20c. LOCATION — City or Town, State CAMBRIDGE, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>General D. Bell</i>		22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, P. O. BOX 207, 106 MAIN STREET, EAST NEW MARKET, MD 21631									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		s. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death 1 HOUR				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):					7 DAYS				
{		c. ATHEROSCLEROSIS DUE TO (OR AS A CONSEQUENCE OF):					4 YEARS				
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29c. LICENSE NUMBER D-16609				
							29d. DATE SIGNED (Month, Day, Year) <i>June 12, 1995</i>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL A. MOSKEWICZ MD. 503 BYRN ST. CAMBRIDGE MD. 21613											
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Julie A. Moskewicz</i>									

the same reason, probably
got no reply, so I am
not sure about it.

As far as I can see, the
newspaper is the best place
to publish my work.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2b is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

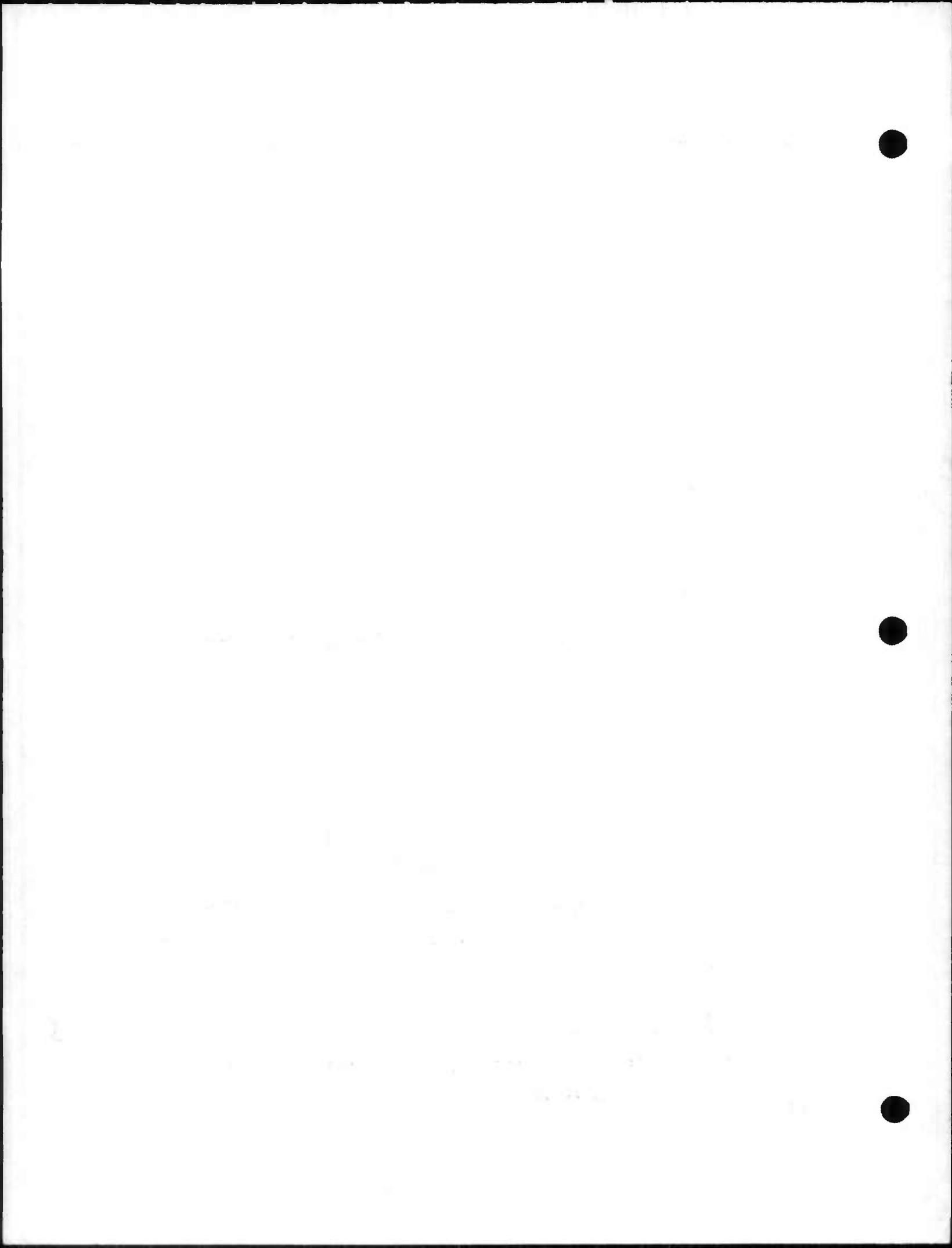
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19201

1. DECEDENT'S NAME (First, Middle, Last) LILA L TAYLOR						2. DATE OF DEATH MONTH MAY DAY 26 YEAR 1995	3. TIME OF DEATH 6:53 A M
4. SOCIAL SECURITY NUMBER 224-12-5861		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) 10/27/19	8. BIRTHPLACE (State or Foreign Country) North Carolina
9a. FACILITY NAME (If not institution, give street and number) Ft. Washington Med. Center			9b. CITY, TOWN OR LOCATION OF DEATH Ft. Washington			9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Md.	10b. COUNTY P.G.	10c. CITY, TOWN OR LOCATION Oxon Hill				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2134 Alice Ave.				10f. ZIP CODE 20745		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) John Brown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Henrietta Stokes			
19a. INFORMANT'S NAME (Type/Print) Charles L. Brown			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10 above				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Maryland Nat'l. Mem. Park			DATE 6/1/95	20c. LOCATION — City or Town, State Laurel, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Xany St. Cratt			22. NAME AND ADDRESS OF FACILITY H.S. Washington & Sons, Inc. 4925 Burroughs Ave., N.E.				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>respiratory + cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. _____ DUE TO (OR AS A CONSEQUENCE OF):							
c. _____ DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) MA		28b. TIME OF INJURY MA	28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED MA	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) MA		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MA					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER Carl Johnson			
29b. SIGNATURE AND TITLE OF CERTIFIER Carl Johnson				29d. DATE SIGNED (Month, Day, Year) 5/27/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CARL JOHNSON 6188 Oxon Hill RD., Oxon Hill, MD 20745							
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE John Andrew Marshall					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

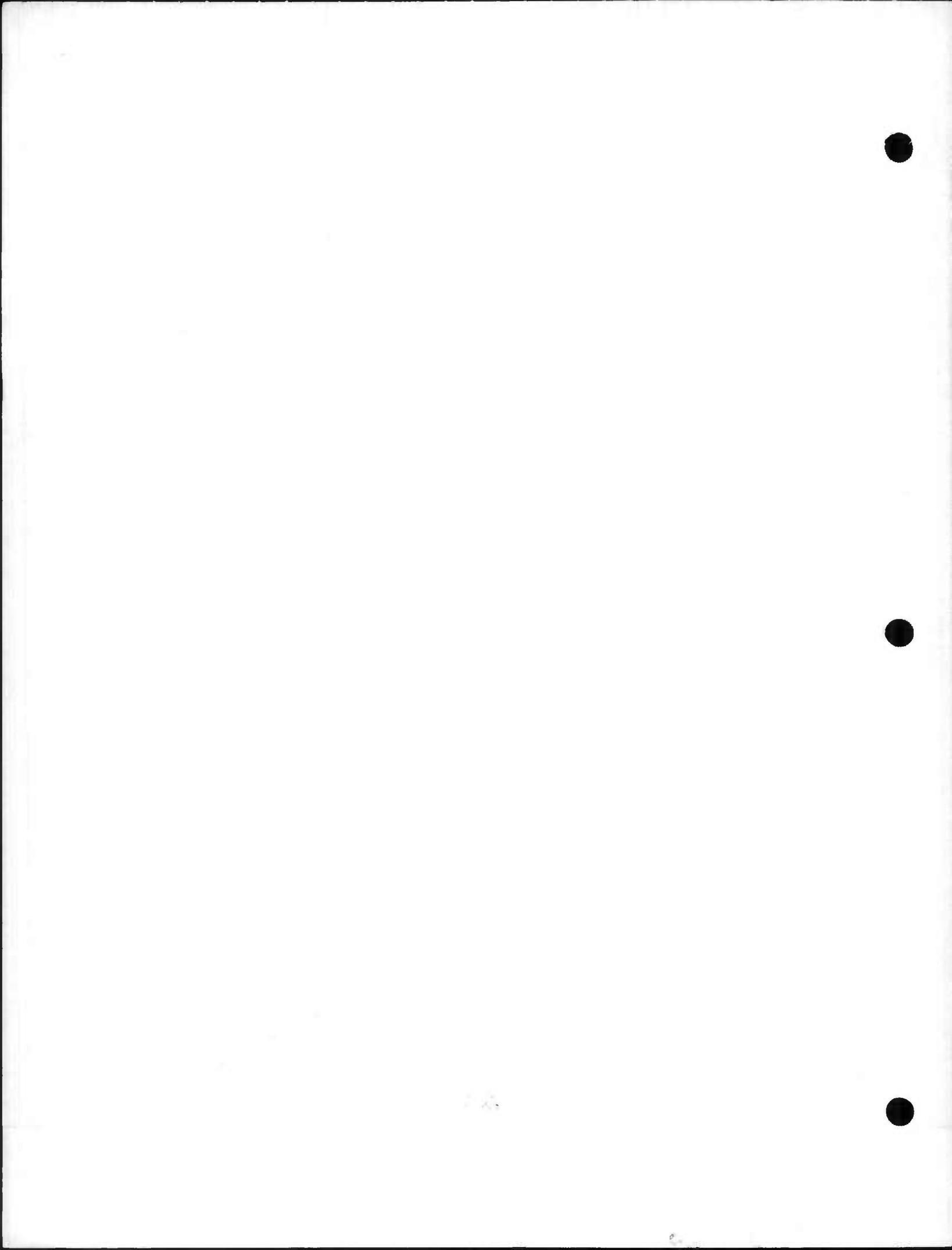
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Roy Ernest Thieme						2. DATE OF DEATH MONTH 5 DAY 25 YEAR 95		3. TIME OF DEATH 12 35 P.M.		
4. SOCIAL SECURITY NUMBER 217 36 6777		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 99 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Mar. 24, 1896		8. BIRTHPLACE (State or Foreign Country) Kansas		
9a. FACILITY NAME (If not institution, give street and number) 5507 Brooks Woods Rd.			9b. CITY, TOWN OR LOCATION OF DEATH Lothian			9c. COUNTY OF DEATH Anne Arundel				
10a. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Lothian			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10g. CITIZEN OF WHAT COUNTRY? United States			
10e. STREET AND NUMBER 5507 Brooks Woods Road			10f. ZIP CODE 20711			14. RACE — American Indian, Black, White, etc. White				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: XX			16. KIND OF BUSINESS/INDUSTRY Self			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Farmer			18b. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Smith					
19a. INFORMANT'S NAME (Type/Print) Arthur Thieme		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5505 Brooks Woods Rd. Lothian, Md. 20711			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) First Lutheran Church Cemetery		DATE 5/29/95	20c. LOCATION — City or Town, State Bowie Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans		22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Diabetes Potential Tumor								Approximate Interval Between Onset and Death 1 yr		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Natural Pending Investigation Accident Suicide Homicide								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH Natural Pending Investigation Accident Suicide Homicide		28a. DATE OF INJURY (Month, Day, Year) 5/25/95		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28d. DESCRIBE HOW INJURY OCCURRED						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year) 5/25/95		
29b. SIGNATURE AND TITLE OF CERTIFIER Wayne D. Bierbaum		29c. LICENSE NUMBER D38563								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wayne D. Bierbaum 134 Lansdowne Rd., West River, MD								31. DATE FILED (Month, Day, Year) JUN 05 1995		
32. REGISTRAR'S SIGNATURE Julie Shuler-Pearl										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

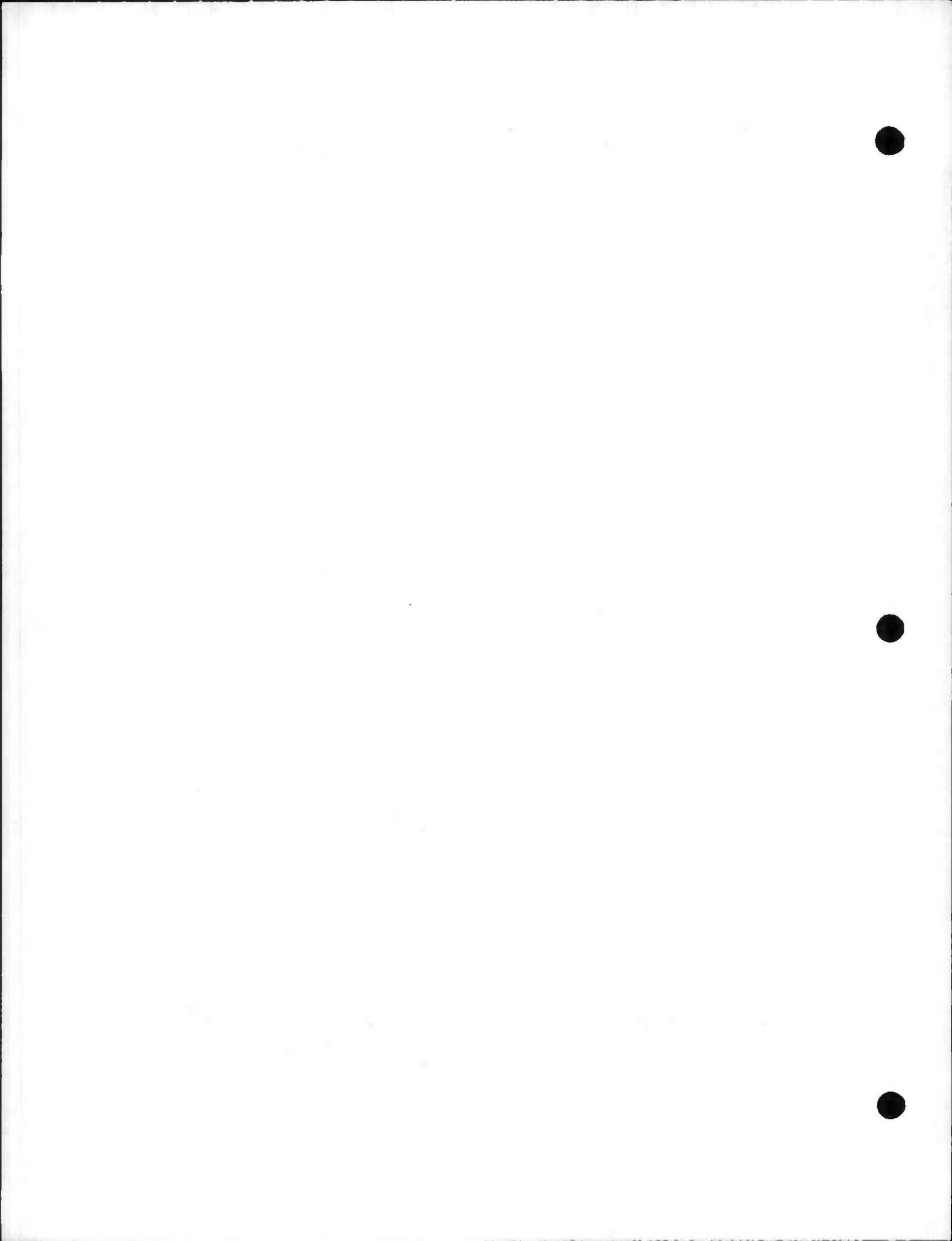
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

95 19203

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		D <i>Kathryn Tyner</i>				DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER 216-58-6469		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 5, 1953	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) 9449 Trevino Terrace		9b. CITY, TOWN OR LOCATION OF DEATH Laurel				9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEASED							
10e. STATE Maryland	10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9449 Trevino Terrace				10f. ZIP CODE 20708		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Widowed	12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10	16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker	16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) William Chester				18. MOTHER'S NAME (First, Middle, Maiden Surname) Geraldine Davis			
19e. INFORMANT'S NAME (Type/Print) Geraldine D. Tyner				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9449 Trevino Terrace, Laurel, Maryland 20708			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		DATE 6/3/95	20c. LOCATION — City or Town, State Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Susan L. Davis</i>				22. NAME AND ADDRESS OF FACILITY Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Squamous cell carcinoma</i> Approximate Interval Between Onset and Death Year							
DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one)		1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Augusto P. Rodriguez MD, 5009 Rayburn Ct. Cr. Md 20748</i>		31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE <i>Julin Dawson-Randall</i>		33. LICENSE NUMBER D 21230	
						34. DATE SIGNED (Month, Day, Year) June 2, 1995	



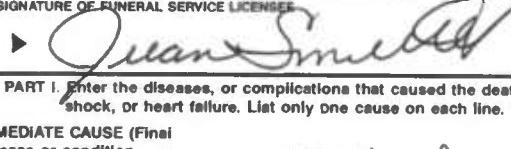
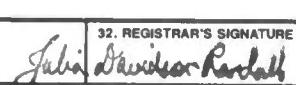
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

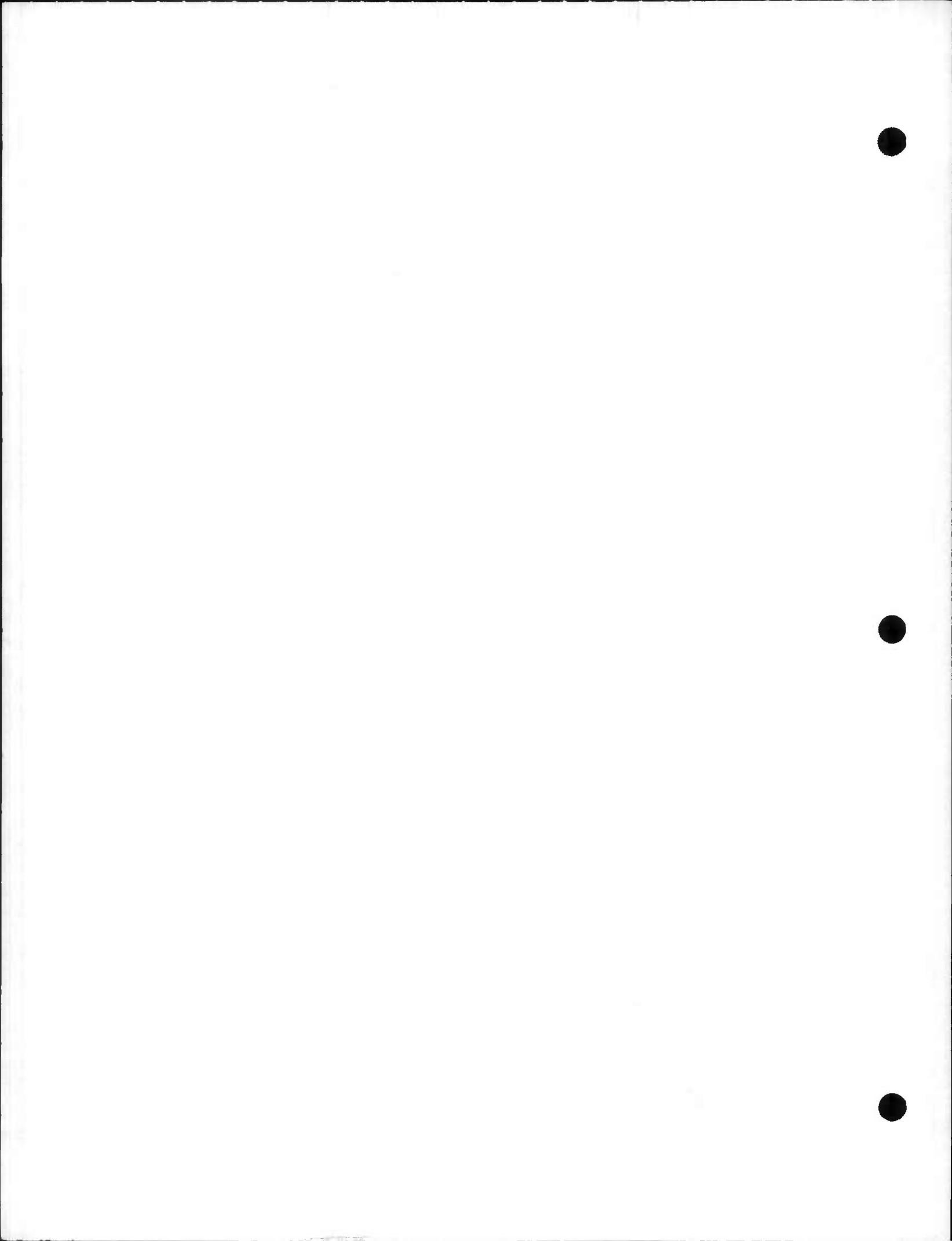
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
Avis McLean Thomas												June 7, 1995	5:25 p.m. M		
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)		
578-72-2136		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		42 YRS.		MONTHS		DAYS		HOURS MIN.		12/17/52	Washington, DC		
9a. FACILITY NAME (If not institution, give street and number)												9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH		
6801 TEMPLE HILL ROAD												TEMPLE HILL	PG		
RESIDENCE OF DECEDENT															
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?				
Md.	PG		Temple Hill								<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER												10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?		
6801 Temple Hill Road												20748	USA		
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		13. WAS DECEDENT OF NARVANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.)								14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:								Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY											
Elementary/Secondary (0-12) 12 Yrs		College (14 or 5+) 3 Yrs		Federal Government								Judicial System			
17. FATHER'S NAME (First, Middle, Last)												18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Curvis McLean												Jeanette Turner			
19a. INFORMANT'S NAME (Type/Print)												19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Jeanette McLean												Same as 10a,b,c,d,e,&f			
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State									
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Maryland Memorial Park		6/12/95		Laurel Md.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE												22. NAME AND ADDRESS OF FACILITY			
												John T. Rhines Co., Inc. 3030 12th St NE, DC 20017			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
b. <u>cerebral astrocytoma</u> DUE TO (OR AS A CONSEQUENCE OF):															
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____ DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?		
<u>Sepiques</u> <u>Subdural hematoma</u>												<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)													
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D43083		29d. DATE SIGNED (Month, Day, Year) ► 6/18/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 													



DIVISION OF VITAL RECORDS, P.O. BOX 687600

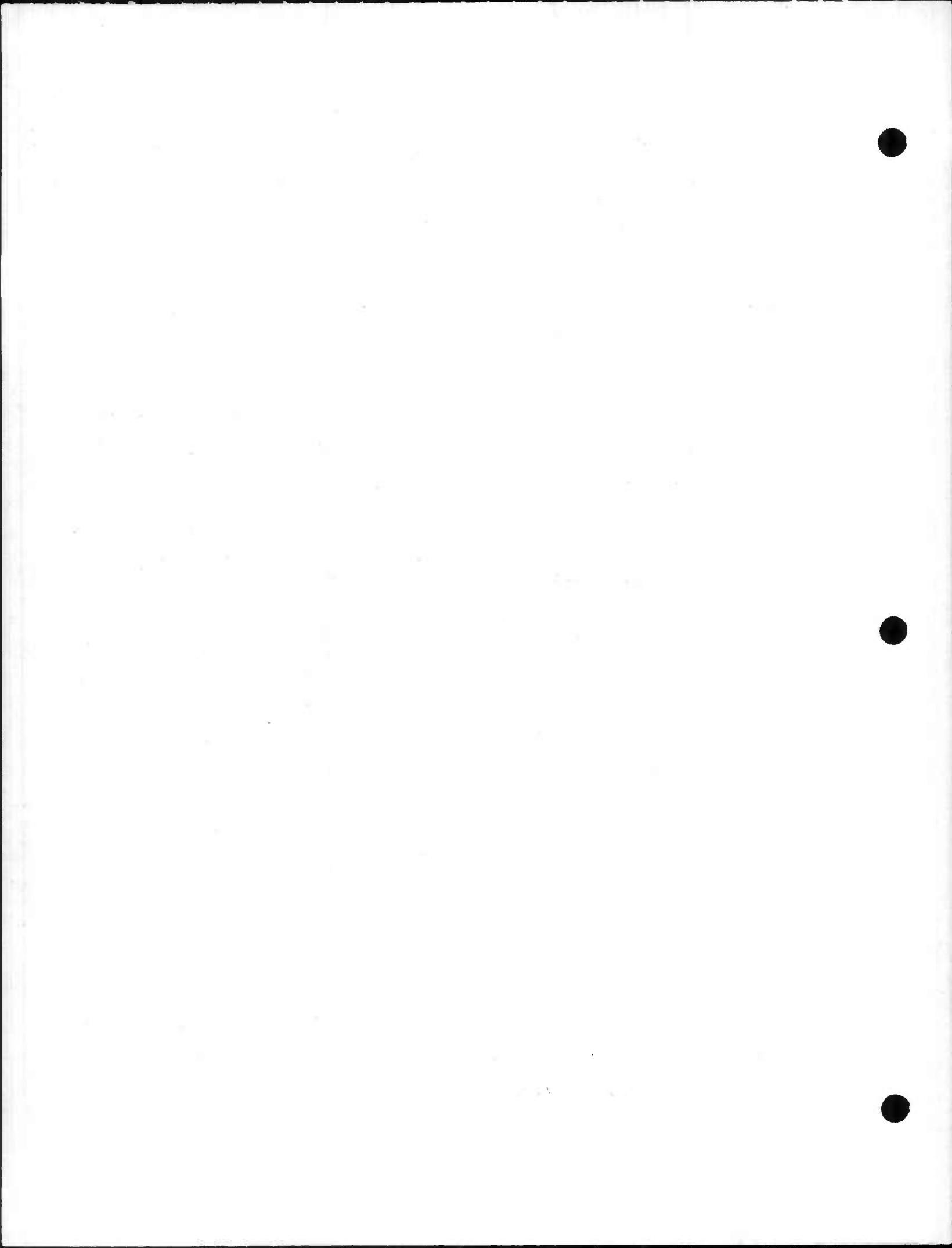
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.									
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 5, 1995										3. TIME OF DEATH 5:30 A M									
1. DECEDENT'S NAME (First, Middle, Last) JOSEPH EDWARD THORNBERRY												7. DATE OF BIRTH (Month, Day, Year) Dec. 22, 1927		8. BIRTHPLACE (State or Foreign Country) Washington, DC							
4. SOCIAL SECURITY NUMBER 577-30-1689		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9a. FACILITY NAME (If not institution, give street and number) 6606 Hillmeade Road		9b. CITY, TOWN OR LOCATION OF DEATH Bowie		9c. COUNTY OF DEATH Prince George's							
RESIDENCE OF DECEDENT												10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6606 Hillmeade Road												10f. ZIP CODE 20720		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Policeman				16b. KIND OF BUSINESS/INDUSTRY County Government															
17. FATHER'S NAME (First, Middle, Last) Henry Edgar Thornberry												18. MOTHER'S NAME (First, Middle, Maiden Surname) Nellie Catherine Sullivan									
19a. INFORMANT'S NAME (Type/Print) Barbara J. Thornberry												19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6606 Hillmeade Road, Bowie, Maryland 20720									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory 6/06/95				DATE 6/06/95		20c. LOCATION — City or Town, State Alexandria, Virginia													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE W.B. Gease												22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 3 months									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardio respiratory failure																					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Metastatic Undifferentiated carcinoma in lung, liver, skeleton, skin & Retroperitoneum																					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Heart transplant																					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED													
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D21294										29d. DATE SIGNED (Month/Day/Year) ► 6/05/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Abdul Nayem, M.D. 3450 Fort Meade Road #100, Laurel, Maryland 20724-2091																					
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE Jahn D. Walker																			



95 19206

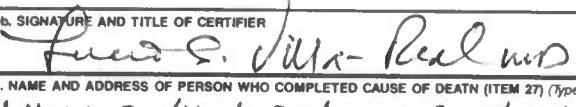
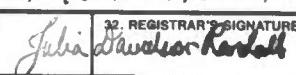
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

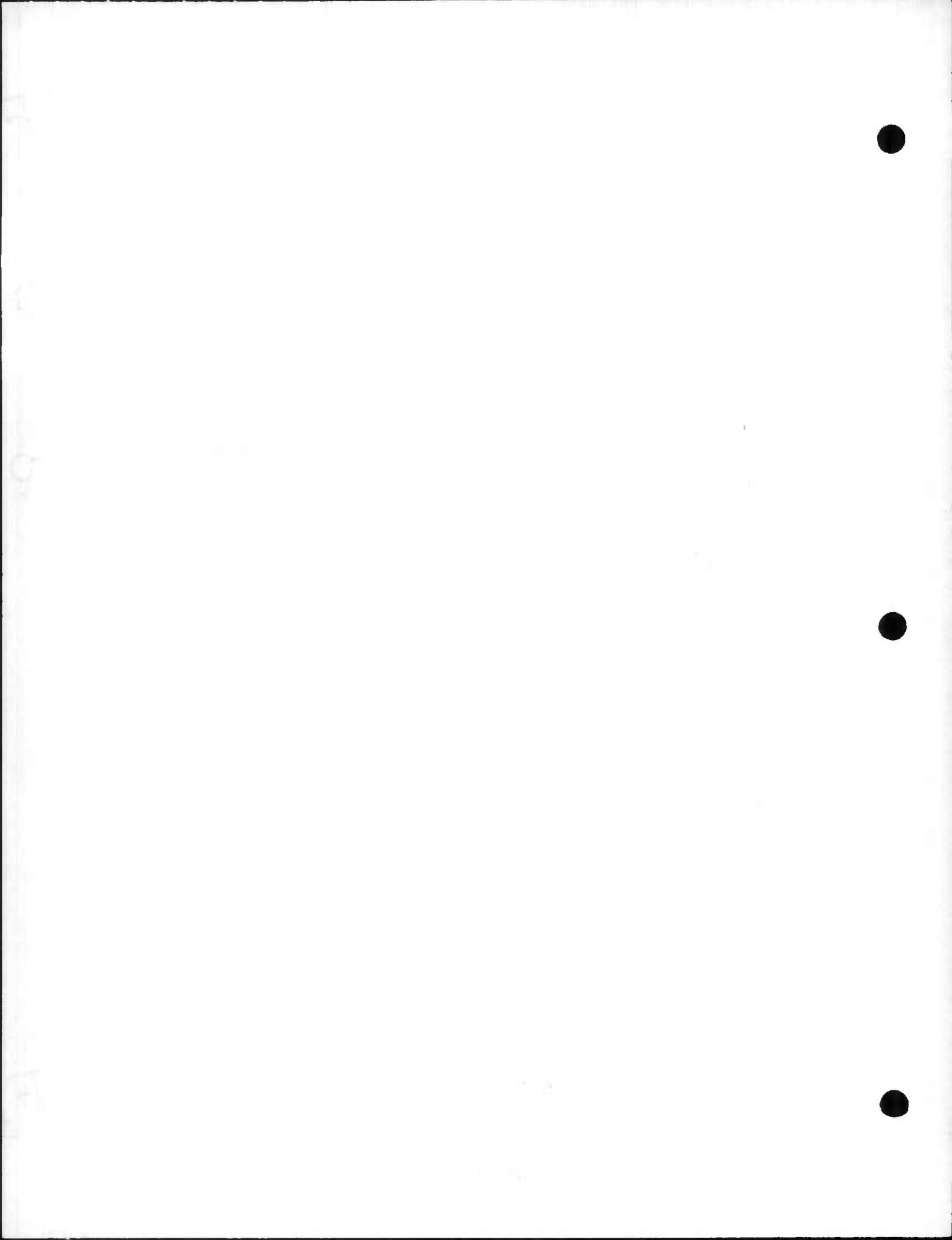
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH P M		
KENNETH J. TILMANN								JUNE 1 - 1995		7:10 P M		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
090-07-4789		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	81 YRS.	MONTHS	DAYS	HOURS	MIN.	1-16-14		New York		
9a. FACILITY NAME (If not institution, give street and number)								9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH		
SOUTHERN MARYLAND HOSPITAL								CHINTON		PRINCE GEORGES		
RESIDENCE OF DECEDED												
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?				
Maryland	Prince George's	Temple Hills						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER								10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?			
5109 Hagan Road								20748	USA			
11. MARITAL STATUS		12. WAS DECEDED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. II				13. WAS DECEDED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDED'S EDUCATION (Specify only highest grade completed)		16a. DECEDED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12)		Map Printer				Federal Government						
17. FATHER'S NAME (First, Middle, Last)								18. MOTHER'S NAME (First, Middle, Maiden Surname)				
Ernest Tilmann								Gennie Schickel				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)				20c. LOCATION — City or Town, State						
Demers		5109 Hagan Road Temple Hills, Maryland 20748				Cheltenham, Maryland						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State				
		Maryland Veteran's Cem. 6-6-95						George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY				
								George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								19 DAYS				
a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF):								b. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF):				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								c. DUE TO (OR AS A CONSEQUENCE OF):				
{								d. DUE TO (OR AS A CONSEQUENCE OF):				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
CHRONIC OBSTRUCTIVE PULMONARY DISEASE HYPERTENSION												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)										
		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
29a. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)		
LUCIO S. VILLA-REAL, M.D., #2 ST. PATRICK'S DRIVE, WALDORF, MD. 20603								D 155 13		► 06/01/95		
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE 										
JUN 05 1995												



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

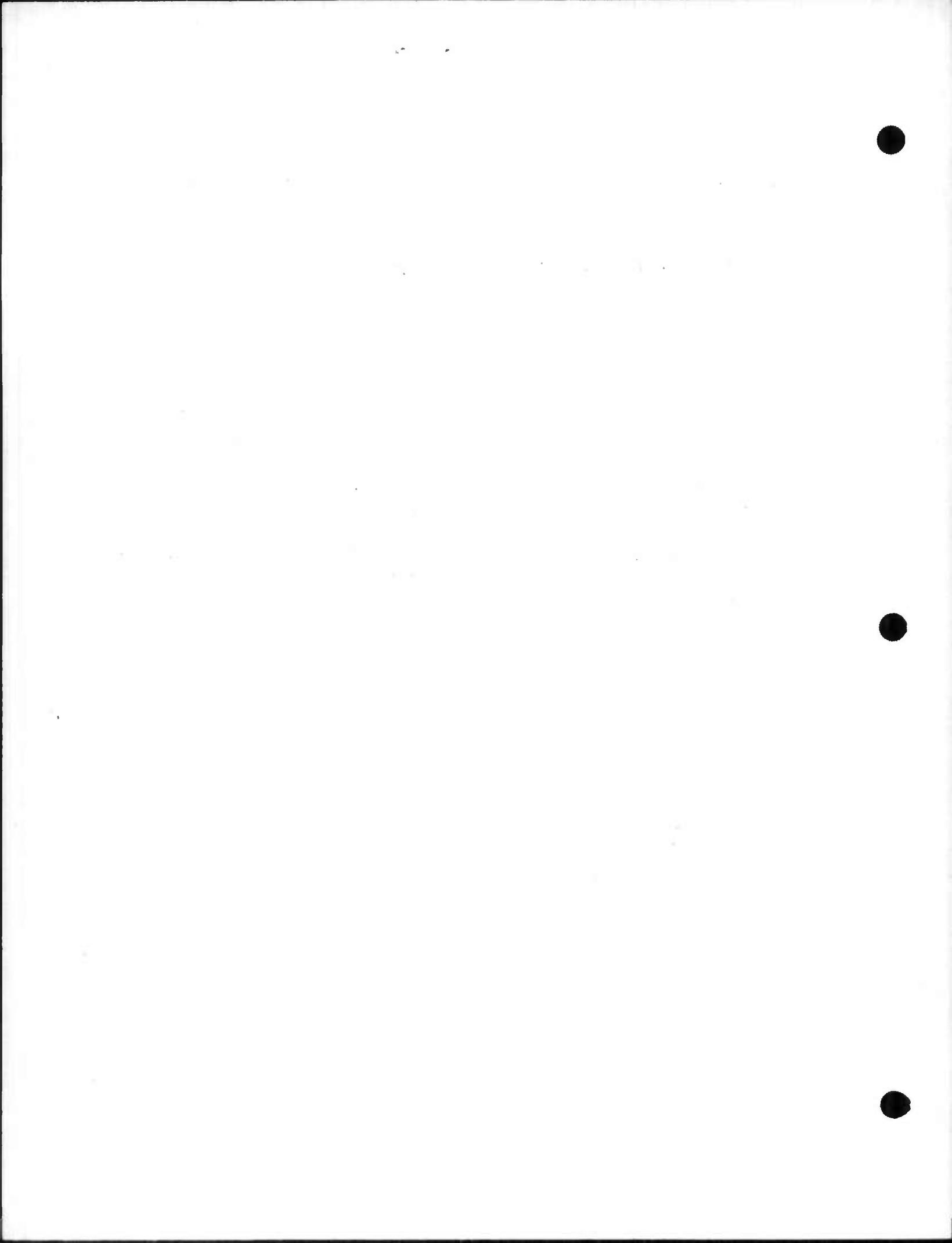
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Last) IRMA Virginia TURNER										2. DATE OF DEATH MONTH JUNE DAY 10 YEAR 1995	3. TIME OF DEATH 07:30 M
4. SOCIAL SECURITY NUMBER 212-62-0344		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 18, 1924		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) ST. MARY'S HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH LEONARDTOWN	
9c. COUNTY OF DEATH ST. MARY'S											
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Temple Hills				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4007 Murdock Street					10f. ZIP CODE 20748			10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0			16b. KIND OF BUSINESS/INDUSTRY Farmer						
17. FATHER'S NAME (First, Middle, Last) George Dudley Turner					18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Ann Swann						
19a. INFORMANT'S NAME (Type/Print) Mildred A. Keese					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4007 Murdock Street, Temple Hills, Maryland 20748						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Cemetery or Other Place) Trinity Church Cemetery			DATE 6-13-95		20c. LOCATION — City or Town, State Newport, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEES Mark G. Brohawn		22. NAME AND ADDRESS OF FACILITY THE HUNT FUNERAL HOME, INC.			P.O. BOX 156, WALDORF, MARYLAND 20604						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
s. <i>Metastatic Carcinoma vulva.</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>DR. JAMES C. BOYD</i>		29c. LICENSE NUMBER D 27189		29d. DATE SIGNED (Month, Day, Year) ► 6/10/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. JAMES C. BOYD											
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Julia Dawson Randall</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

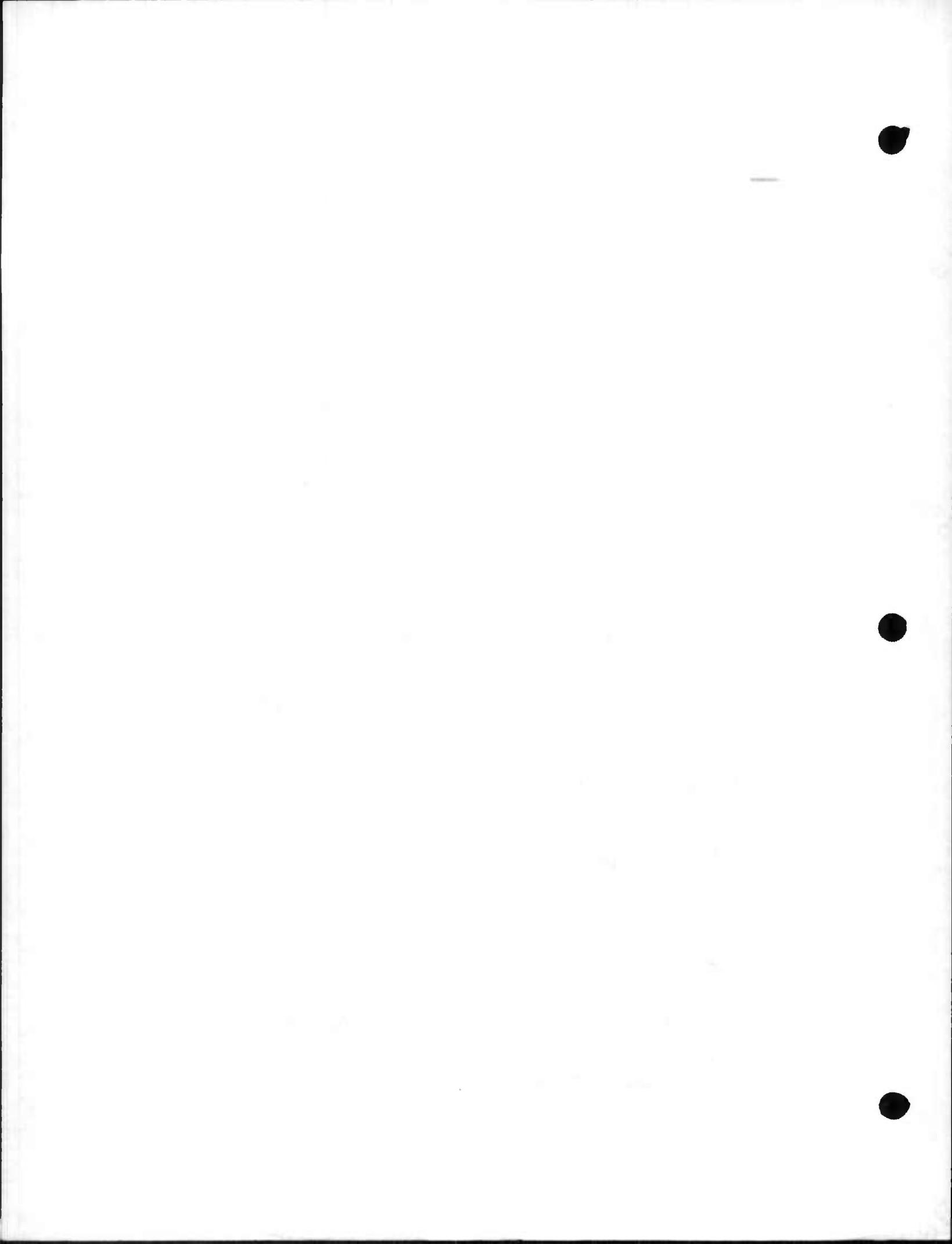
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 95 19208			
1. DECEDENT'S NAME (First, Middle, Last) Clyde L. Thompson, Jr.												2. DATE OF DEATH MONTH 6 DAY 8 YEAR 1995	3. TIME OF DEATH 1320		
4. SOCIAL SECURITY NUMBER 217-214-42-0002		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) Dec. 15, 1942		8. BIRTHPLACE (State or Foreign Country) Illinois					
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital												9b. CITY, TOWN OR LOCATION OF DEATH baltimore		9c. COUNTY OF DEATH ---	
10a. STATE Maryland		10b. COUNTY Frederick		10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 415 Navaho Dr.				10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? United States							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) - Engineer Technician				16b. KIND OF BUSINESS/INDUSTRY county Government									
17. FATHER'S NAME (First, Middle, Last) Clyde L. Thompson, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kay - Stone											
19a. INFORMANT'S NAME (Type/Print) Lynn M. Murphy				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 415 Navaho Dr./ Frederick, Md. 21701											
20a. METHOD OF DISPOSITION Burial 1 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Resthaven Memorial Cem. 6-11				DATE	20c. LOCATION — City or Town, State Frederick, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Raymond Peterson				22. NAME AND ADDRESS OF FACILITY Stauffer Funeral Home											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →				a. Acute Respiratory Distress syndrome DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death one week							
				b. Sepsis DUE TO (OR AS A CONSEQUENCE OF):				two weeks							
				c. Hemorrhagic Pancreatitis DUE TO (OR AS A CONSEQUENCE OF):				three weeks							
				d. Alcohol use				three weeks							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Acute Renal Failure												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED						
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER P08194											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Engelhardt 9268 Broken Timber way Columbia, MD 21045				29d. DATE SIGNED (Month, Day, Year) ► 6/8/95											
31. DATE FILED (Month, Day, Year) JUN 12 1995				32. REGISTRAR'S SIGNATURE John Dawson-Peterson											



DIVISION OF VITAL RECORDS, P.O. BOX 13146,

BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

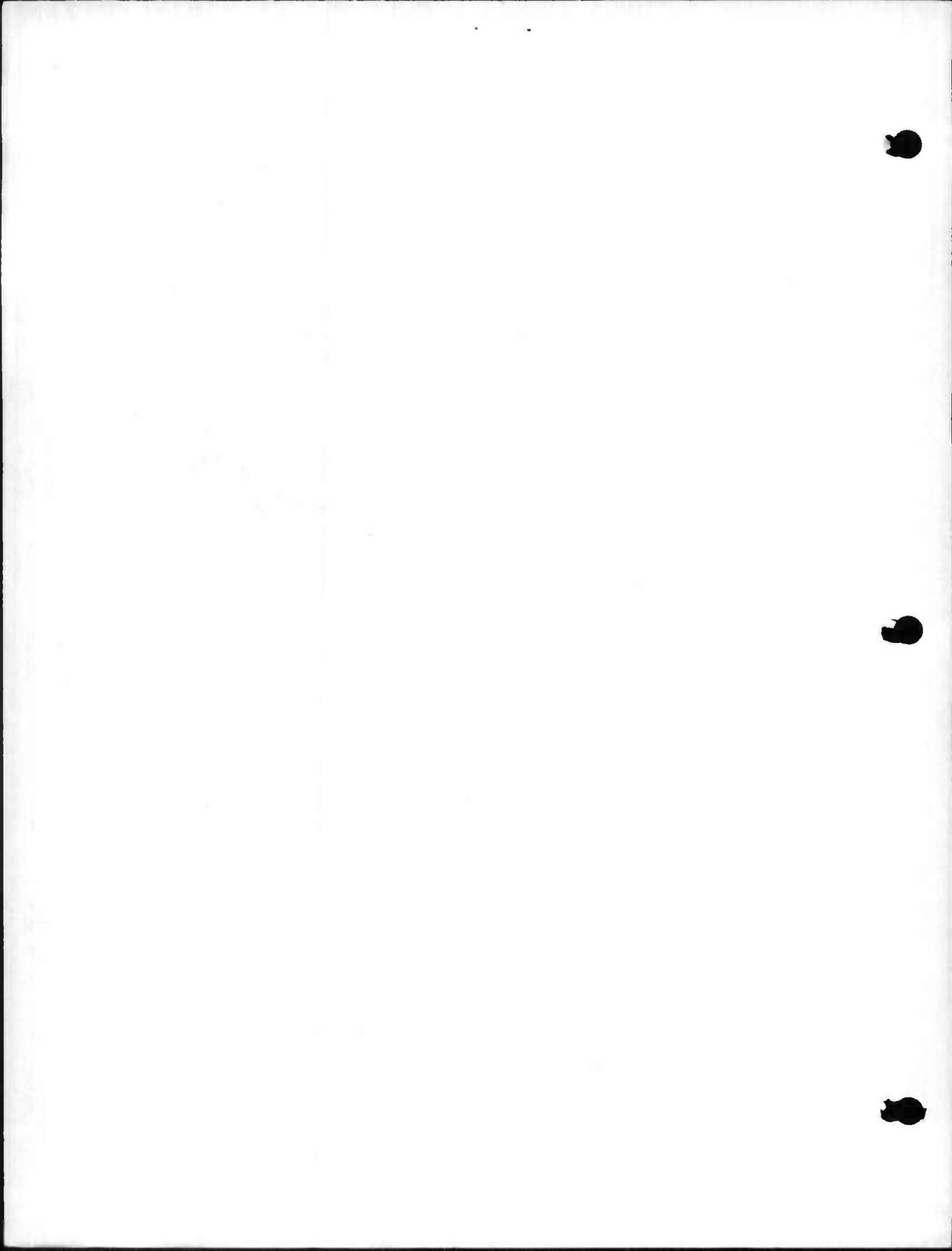
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) ALFRED M. TURNER						2. DATE OF DEATH MONTH JUNE DAY 7 YEAR 1995	3. TIME OF DEATH 3:30PM
4. SOCIAL SECURITY NUMBER 162-07-6594			5. SEX M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) Feb 28, 1907	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
9a. FACILITY NAME (If not institution, give street and number) 715 Maiden Choice Lane			9b. CITY, TOWN OR LOCATION OF DEATH Catonsville			9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 715 Maiden Choice Lane				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman			16b. KIND OF BUSINESS/INDUSTRY Industrial Equipment	
17. FATHER'S NAME (First, Middle, Last) George L. Turner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertha Unbwust			
19a. INFORMANT'S NAME (Type/Print) Mrs. Brent Owens				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9393 Furrow Avenue Ellicott City, MD 21043			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Bloomingdale Cemetery			20c. LOCATION — City or Town, State Luzerne Co., PA.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Sherman A. Collins				22. NAME AND ADDRESS OF FACILITY Harry H Witzke Funeral Home Inc. 4112 Old Columbia Pike Ellicott City 21043			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): b. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Prostate Cancer stage IV DUE TO (OR AS A CONSEQUENCE OF): d. _____							
Approximate Interval Between Onset and Death 3 days							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic anemia, COPD, AIDS.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 030575					
29b. SIGNATURE AND TITLE OF CERTIFIER John X. Murphy, MD		29d. DATE SIGNED (Month, Day, Year) ► 6-8-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Murphy, MD 2 North North Columbia Rd 21045							
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE Julie A. Wilson-Randall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

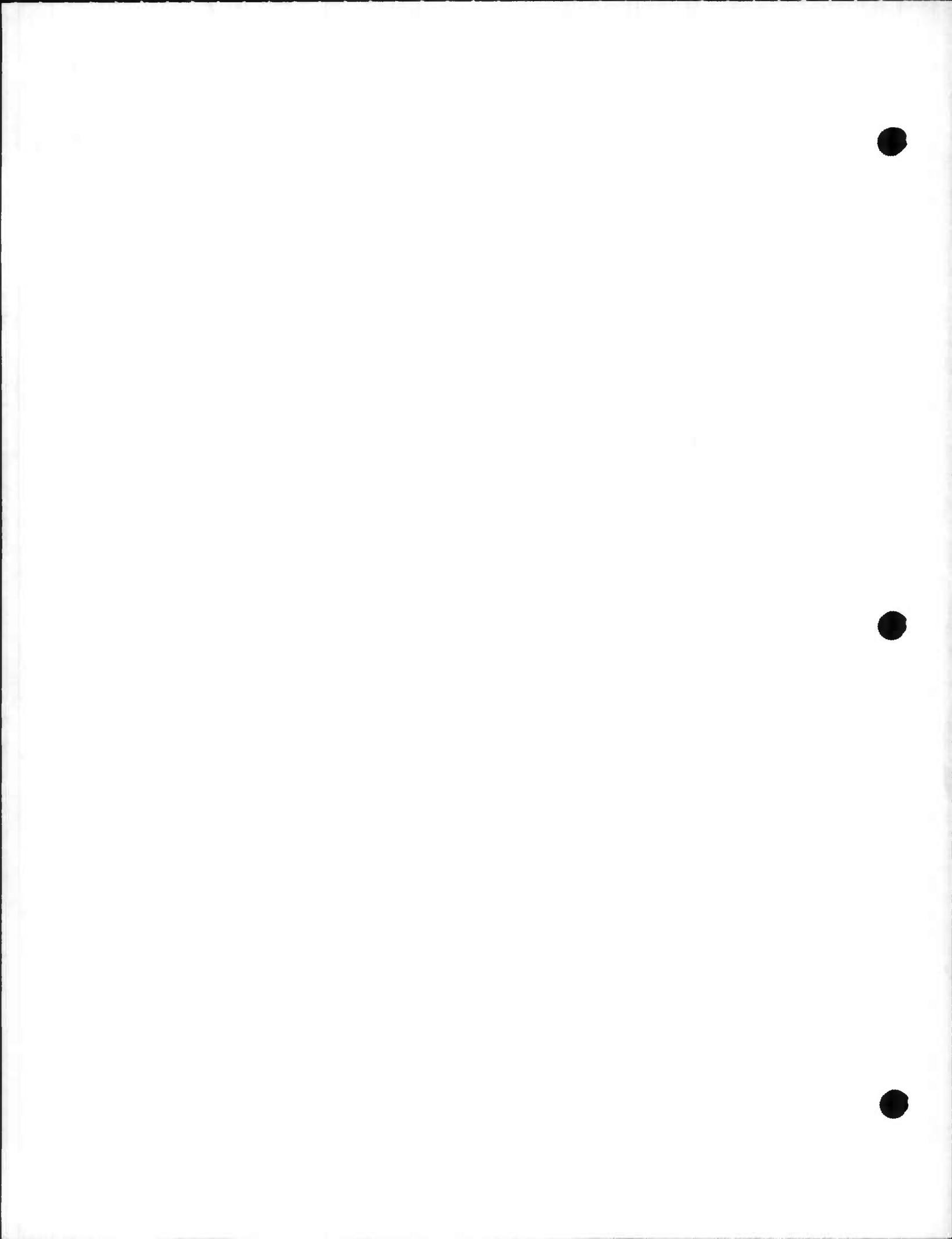
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	
Rita O. Vincent										June 2, 1995	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		3. TIME OF DEATH			
214-28-9845		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	61 YRS.	MONTHS	DAYS	HOURS	MIN.	11:35 A M			
9a. FACILITY NAME (If not institution, give street and number)										7. DATE OF BIRTH (Month, Day, Year)	
Golden Oaks Nursing Home										Oct. 2, 1933	
9b. CITY, TOWN OR LOCATION OF DEATH										8. BIRTHPLACE (State or Foreign Country)	
Laurel										Maryland	
9c. COUNTY OF DEATH										PRINCE GEORGES	
RESIDENCE OF DECEDENT											
10e. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
Maryland		Anne Arundel		Laurel						10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
3510 Spring Road		20724									
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Black				14. RACE — American Indian, Black, White, etc. Specify: Black	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)		College (1-4 or 5+)				Laundry Worker				Laundry	
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Sidney Vincent										Grace	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Wendy Pearson (Niece)										8269 Deerfield Cir., Severn, MD 21144	
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Mt. Zion Ch. Cemetery				6/7		Laurel, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY									
<i>Sandra K. Bowden</i>		SNOWDEN FUNERAL HOME, P.A.									
ROCKVILLE, MD 20850											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
b. <i>BLADDER CANCER</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. <i>Respiratory Arrest</i> DUE TO (OR AS A CONSEQUENCE OF):										2 years	
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)									
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									
29a. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or town, State)					
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
<i>Sabrina Martin</i>						045014		► 6/5/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
F. Sabrina MARTIN 10 7850 Van Dyke #420 Laurel MD 20707											
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE									
JUN 06 1995		<i>Juliie [Signature]</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

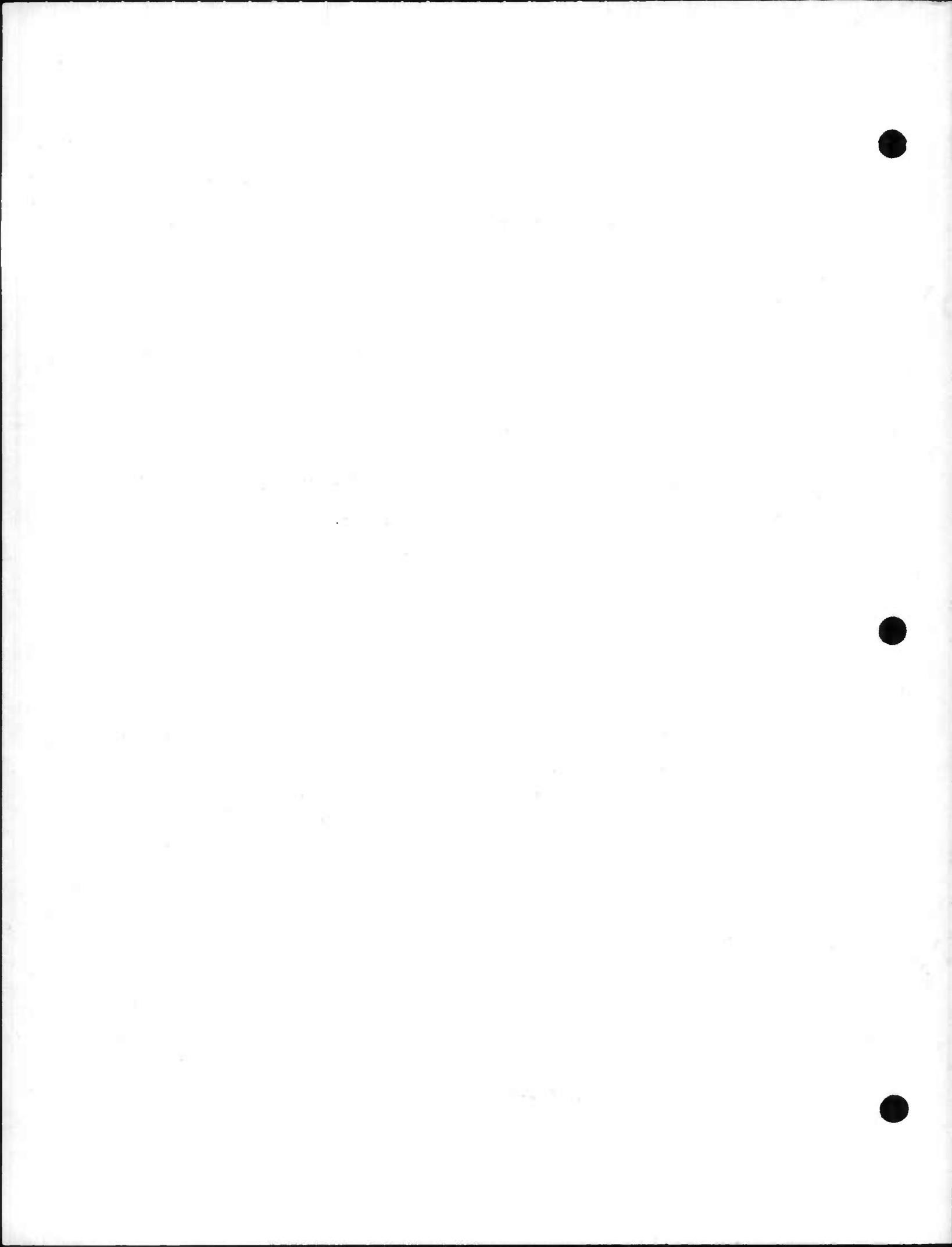
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR															
1. DECEDENT'S NAME (First, Middle, Last) Erma L. Valentine												2. DATE OF DEATH MONTH 5	DAY 27	YEAR 95	3. TIME OF DEATH 8:45 A M
4. SOCIAL SECURITY NUMBER 577-20-1318		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) October 14, 1906		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION LaPlata		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									
10e. STREET AND NUMBER 9308 Winkler Lane				10f. ZIP CODE 20646		10g. CITIZEN OF WHAT COUNTRY? United States									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES NO		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cartographer		16b. KIND OF BUSINESS/INDUSTRY U.S. Government											
17. FATHER'S NAME (First, Middle, Last) William Henry Ford, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Lawson											
19a. INFORMANT'S NAME (Type/Print) Frances Isaksen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13823 Lord Fairfax Pl. Upper Marlboro, MD 20772											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		DATE 5/30		20c. LOCATION — City or Town, State Brentwood, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans Pres.				22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A.											
				16000 Annapolis Road Bowie, MD 20715											
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <i>Resp. Failure</i> <i>pul edema + pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Germantown MD 20876							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER M. Mansour MD		29c. LICENSE NUMBER D46549		29d. DATE SIGNED (Month, Day, Year) 5/27/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mohamed S. Mansour															
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE John J. Jackson, Jr.													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

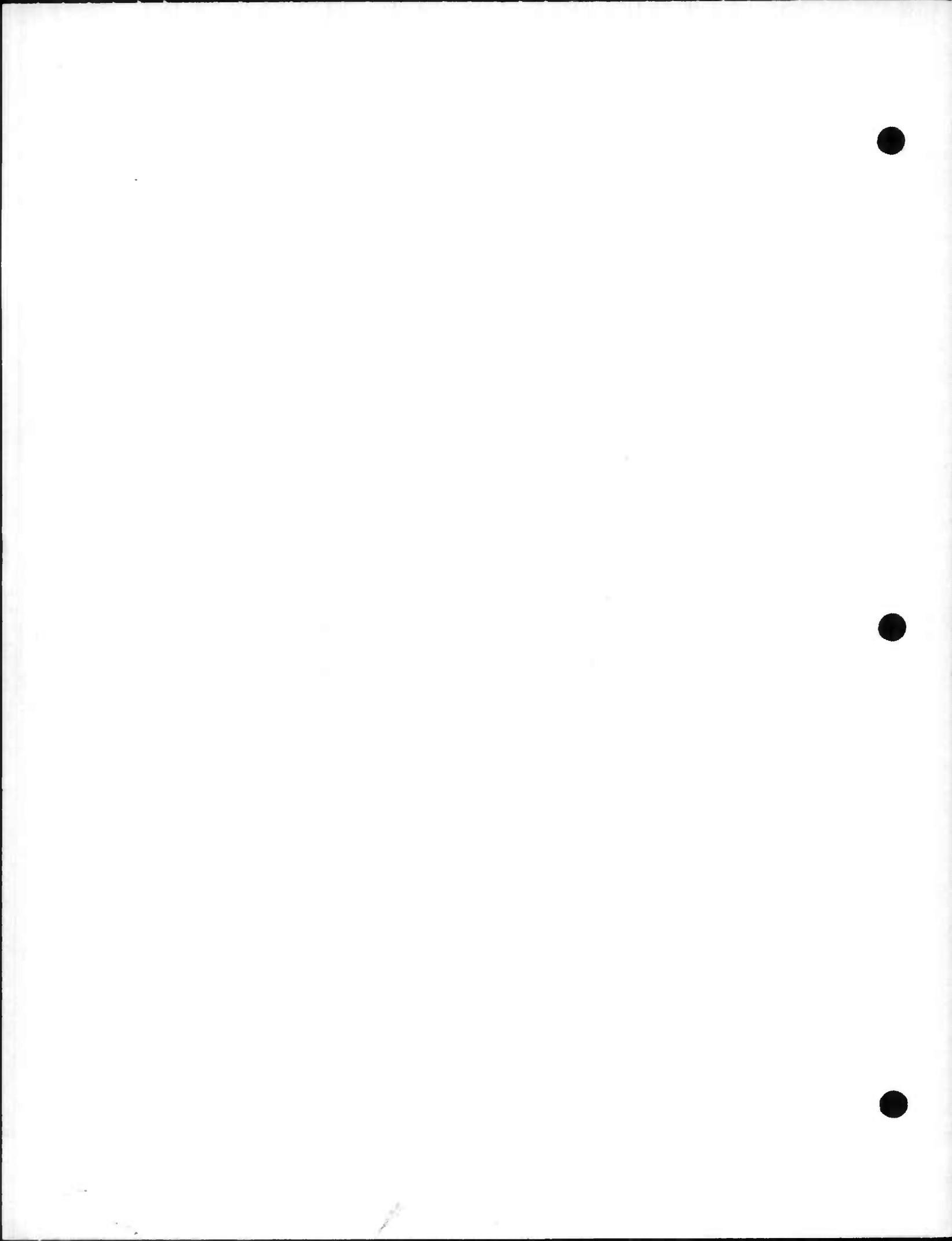
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH 6 DAY 4 YEAR 95										3. TIME OF DEATH 11:05 PM			
1. DECEDENT'S NAME (First, Middle, Last) <i>Adolph Abraham Weiss</i>		4. SOCIAL SECURITY NUMBER 053-14-4347		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) JUNE 15, 1906		8. BIRTHPLACE (State or Foreign Country) GERMANY			
9a. FACILITY NAME (If not institution, give street and number) HOLY CROSS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SILVER SPRING										9c. COUNTY OF DEATH MONTGOMERY			
RESIDENCE OF DECEDENT															
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION POTOMAC										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9509 WINDCROFT WAY		10f. ZIP CODE 20854										10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) SALESMAN		17. FATHER'S NAME (First, Middle, Last) MEYER WEISS		18. MOTNER'S NAME (First, Middle, Maiden Surname) LENA BRENNER		19. INFORMANT'S NAME (Type/Print) RICHARD WEISS (SON)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9509 WINDCROFT WAY — POTOMAC, MARYLAND 20854					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) JUDEAN MEMORIAL GARDENS		20c. DATE 6/16		20c. LOCATION — City or Town, State OLNEY, MARYLAND									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald A. Stone</i>		22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE — ROCKVILLE, MD. 20852													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. <i>Acute Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):															
b. <i>Coronary Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF):															
c. <i>Atherosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF):															
d. _____															
Approximate Interval Between Onset and Death 48 hrs															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i>															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hewson S. Galus</i>		29c. LICENSE NUMBER D25808		29d. DATE SIGNED (Month, Day, Year) ► 6/5/85											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 10313 Beagle Ave Silver Spring Md 20902															
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE <i>Suzanne R. Riddle</i>													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

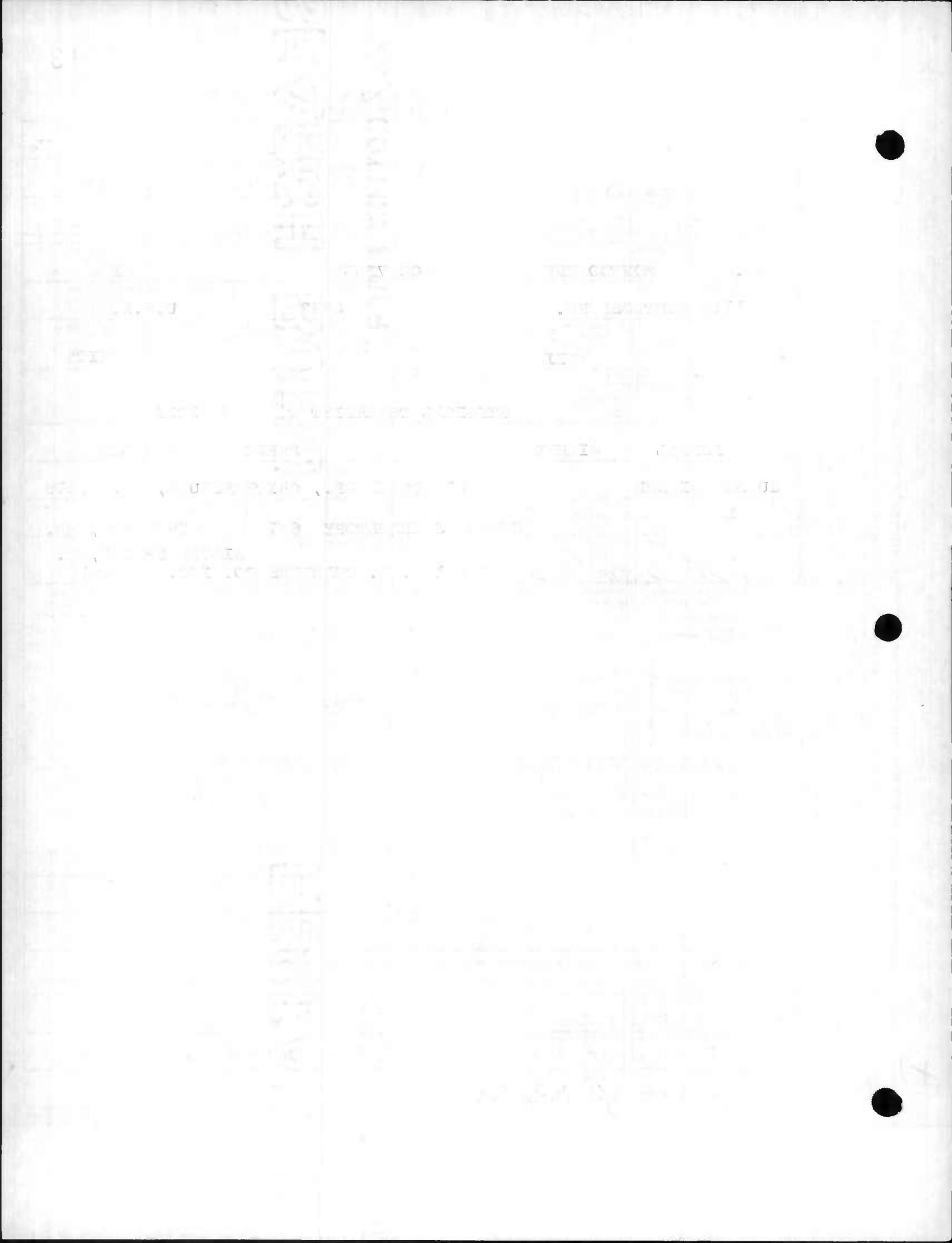
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) LOUIS L. WIENER										2. DATE OF DEATH MONTH 6 DAY 6 YEAR 95	3. TIME OF DEATH 9:35 A				
4. SOCIAL SECURITY NUMBER 111-22-9966		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 5-1-07	8. BIRTHPLACE (State or Foreign Country) NEW YORK								
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington					9b. CITY, TOWN OR LOCATION OF DEATH Rockville, MD		9c. COUNTY OF DEATH Montgomery								
RESIDENCE OF DECEDENT															
10a. STATE MD.	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION ROCKVILLE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER 6111 MONTROSE RD.				10f. ZIP CODE 20852			10g. CITIZEN OF WHAT COUNTRY? U.S.A.								
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PHYSICAL THERAPIST			16b. KIND OF BUSINESS/INDUSTRY MEDICINE										
17. FATHER'S NAME (First, Middle, Last) ISREAL WIENER					18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH GENDLER										
19a. INFORMANT'S NAME (Type/Print) SUSAN WIENER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9803 DOCENA DR., GAITHERSBURG, MD. 20879											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHAMBERS CREMATORIAL			DATE 6/7		20c. LOCATION — City or Town, State RIVERDALE, MD.								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SILVER SPRING, MD. W. W. CHAMBERS CO. INC. 20910											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardio respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Cancer of the Bladder + Prostate</u> DUE TO (OR AS A CONSEQUENCE OF): d. _____															
Approximate Interval Between Onset and Death Immediate 3-6 mos >2 yrs															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____															
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Mary T. Sheehan MD					29c. LICENSE NUMBER D46410			29d. DATE SIGNED (Month, Day, Year) ► 6/6/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary T. Sheehan, MD, 103 Argosy Drive, Gaithersburg, MD															
31. DATE FILED (Month, Day, Year) JUN 08 1995				32. REGISTRAR'S SIGNATURE Lulu Anderson-Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

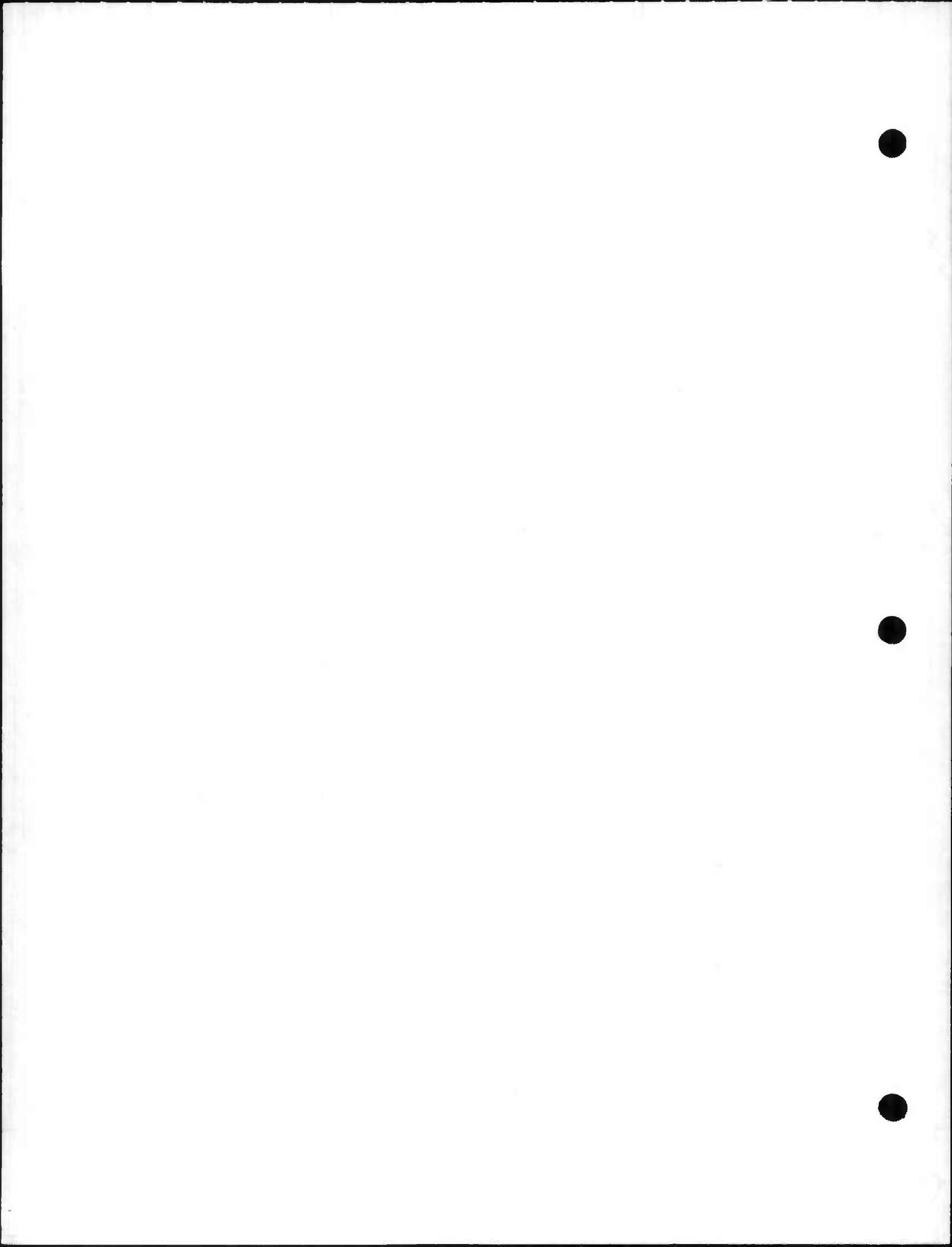
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19214

1. DECEDENT'S NAME (First, Middle, Last) Fong Moon Wen						2. DATE OF DEATH MONTH June DAY 5 YEAR 1995	3. TIME OF DEATH 11:30 P.M.			
4. SOCIAL SECURITY NUMBER 579-144-1790			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) 4-20-24	8. BIRTHPLACE (State or Foreign Country) CANTON, CHINA		
9a. FACILITY NAME (If not institution, give street and number) Mediplex of Montgomery Village				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg, MD			9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT										
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Chevy Chase				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 5053 Bradley Blvd., Apt. 2				10f. ZIP CODE 20815			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES Elementary/Secondary (0-12) College (1-4 or 5+) 12 0			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Asian			14. RACE — American Indian, Black, White, etc.		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laundry Worker			16b. KIND OF BUSINESS/INDUSTRY Laundry Industry					
17. FATHER'S NAME (First, Middle, Last) Hum See				18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable						
19a. INFORMANT'S NAME (Type/Print) Fei Jane Li				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 Argosy Drive, Gaithersburg, Maryland 20878						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Suhair Abulfarag</i>			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			DATE 6/10	20c. LOCATION — City or Town, State Silver Spring, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Suhair Abulfarag</i>				22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →									Approximate Interval Between Onset and Death	
<p>a. Cerebrovascular Coma DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. Ovarian carcinoma DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>									Days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D31391		29d. DATE SIGNED (Month, Day, Year) ► June, 6, 1995						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Suhair Abulfarag, M.D.		31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE <i>Jahn Abulfarag</i>						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

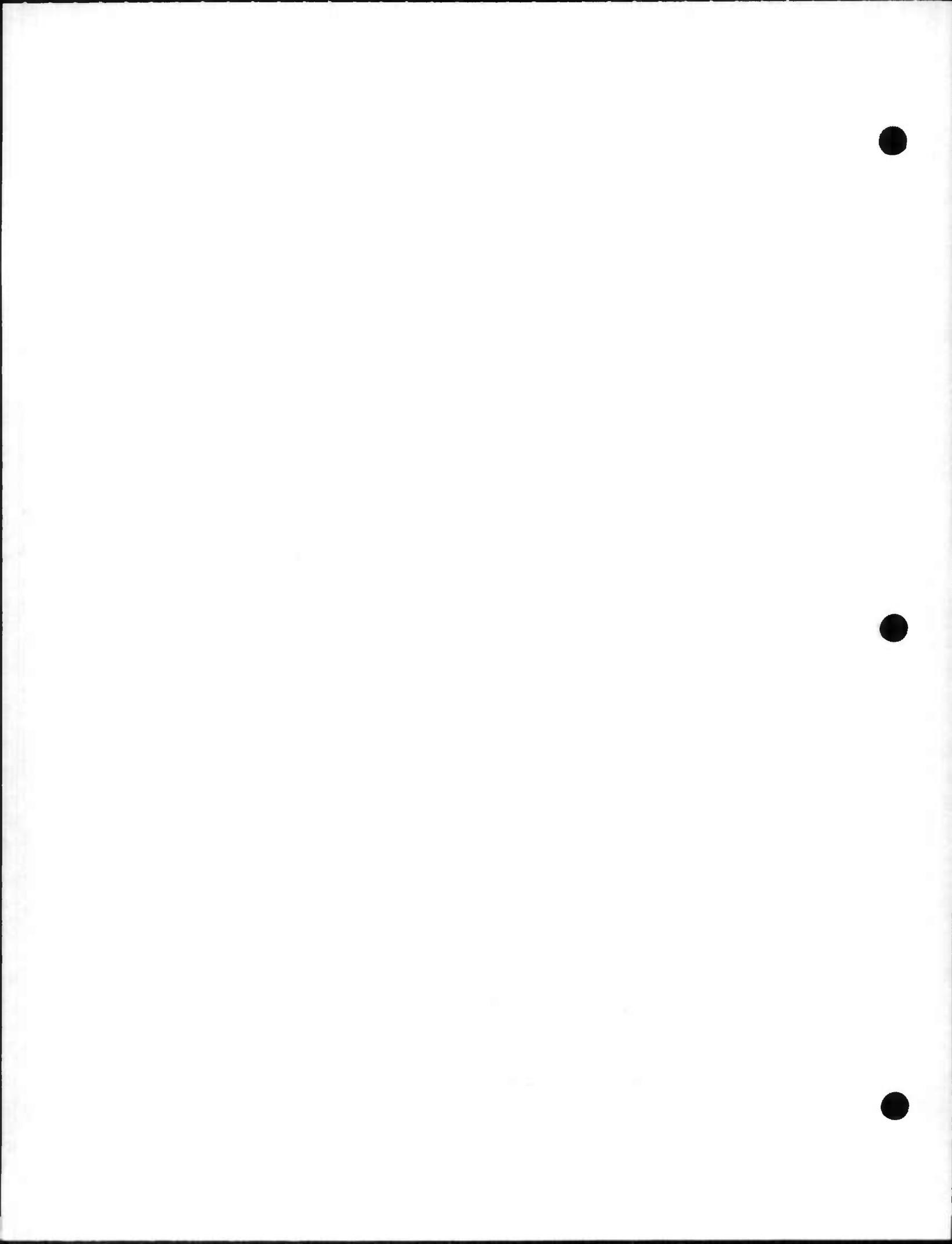
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR MAY 31, 1995										3. TIME OF DEATH 21:41 PM	
1. DECEDENT'S NAME (First, Middle, Last) MARGARET LEONA WARD													
4. SOCIAL SECURITY NUMBER 236-36-1608		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Mar 7, 1926		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPICE UNIT				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND				9c. COUNTY OF DEATH ALLEGANY					
RESIDENCE OF DECEDENT													
10a. STATE MD	10b. COUNTY Allegany	10c. CITY, TOWN OR LOCATION Cumberland				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 14226 Walter Drive				10f. ZIP CODE 21502				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Bruce F. Blauch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel McKenzie									
19a. INFORMANT'S NAME (Type/Print) Loretta Thomas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 2 Box 103F; Keyser, WV 26726									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Pinto Mennonite Cemetery				DATE 06/03	20c. LOCATION — City or Town, State Pinto, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janes F. Scarpelli</i>				22. NAME AND ADDRESS OF FACILITY Scarpelli Funeral Home Cumberland, MD 21502									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 24 HOURS	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. RESPIRATORY ARREST/FAILURE DUE TO (OR AS A CONSEQUENCE OF):													
b. CARCINOMA OF LUNG DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide							
28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY		28c. INJURY AT WORST 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFYING PHYSICIAN (Check only one) 1 <input checked="" type="checkbox"/> C 2 <input type="checkbox"/> M		29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. SIGNATURE AND TITLE OF CERTIFIER <i>DR. William Palin, M.D.</i>		31. DATE FILED (Month, Day, Year) JUN 07 1995				32. REGISTRAR'S SIGNATURE <i>Jane Scarpelli</i>				33. LICENSE NUMBER D34653			
34. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WILLIAM PALIN, M.D., 625 KENT AVENUE, CUMBERLAND, MD 21502												35. DATE SIGNED (Month, Day, Year) JUNE 6, 1995	



95 19216

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

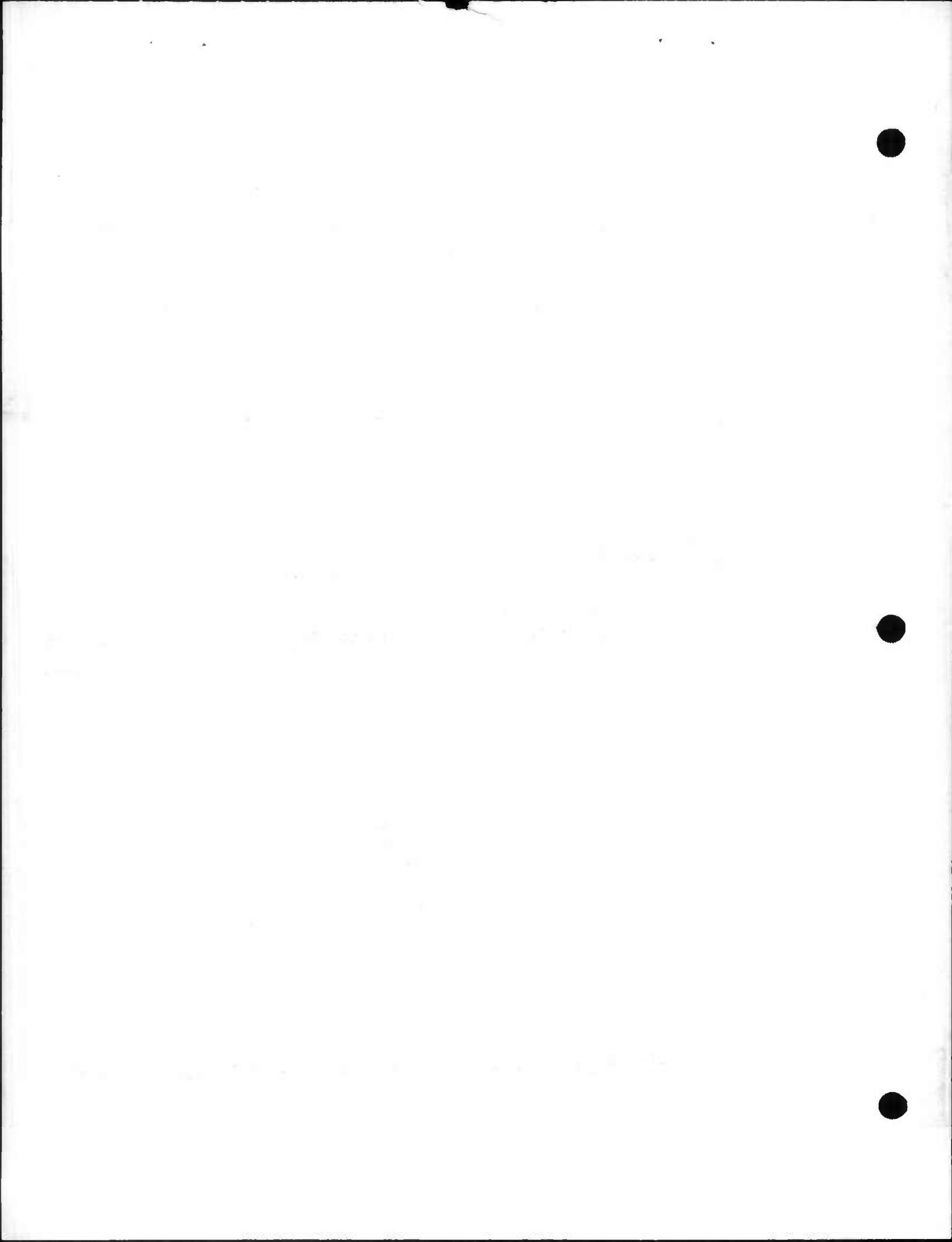
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		LENA REID WILSON								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 2:30 p.m. M	
4. SOCIAL SECURITY NUMBER 214-74-3030		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 28, 1903		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) William Hill Health Care Center		9b. CITY, TOWN OR LOCATION OF DEATH Cambridge								9c. COUNTY OF DEATH Dorchester			
10a. STATE Maryland		10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Cambridge								10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 525 Glenburn Ave.		10f. ZIP CODE 21613								10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 school teacher								18b. KIND OF BUSINESS/INDUSTRY public schools			
17. FATHER'S NAME (First, Middle, Last) John Millard Reid		18. MOTHER'S NAME (First, Middle, Maiden Surname) Kemma Ann Henry											
19a. INFORMANT'S NAME (Type/Print) Mrs. Betty Reid Lloyd		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2417 Canterbury Drive, Cambridge MD 21613											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory, or other place) Dorchester Memorial Park 6/12								DATE 6/12		20c. LOCATION — City or Town, State Cambridge Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Kenneth L. Thomas Jr.		22. NAME AND ADDRESS OF FACILITY Thomas Funeral Home 700 Locust St., Cambridge MD 21613											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Respiratory Insufficiency DUE TO (OR AS A CONSEQUENCE OF):													
b. Bronchitis DUE TO (OR AS A CONSEQUENCE OF):													
c. Hypertension DUE TO (OR AS A CONSEQUENCE OF):													
d.													
Approximate Interval Between Onset and Death 2 weeks 4 weeks 1 yr													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Blindness													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A		28c. INJURY AT WORK 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURED N/A					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A											
29a. CERTIFIER (Check only one) X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER John R. Wilke MD		29c. LICENSE NUMBER 211284								29d. DATE SIGNED (Month, Day, Year) ► 6.9.95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John R. Wilke MD 400 Maryland Ave Cambridge MD 21613													
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE John R. Wilke											



95 19217

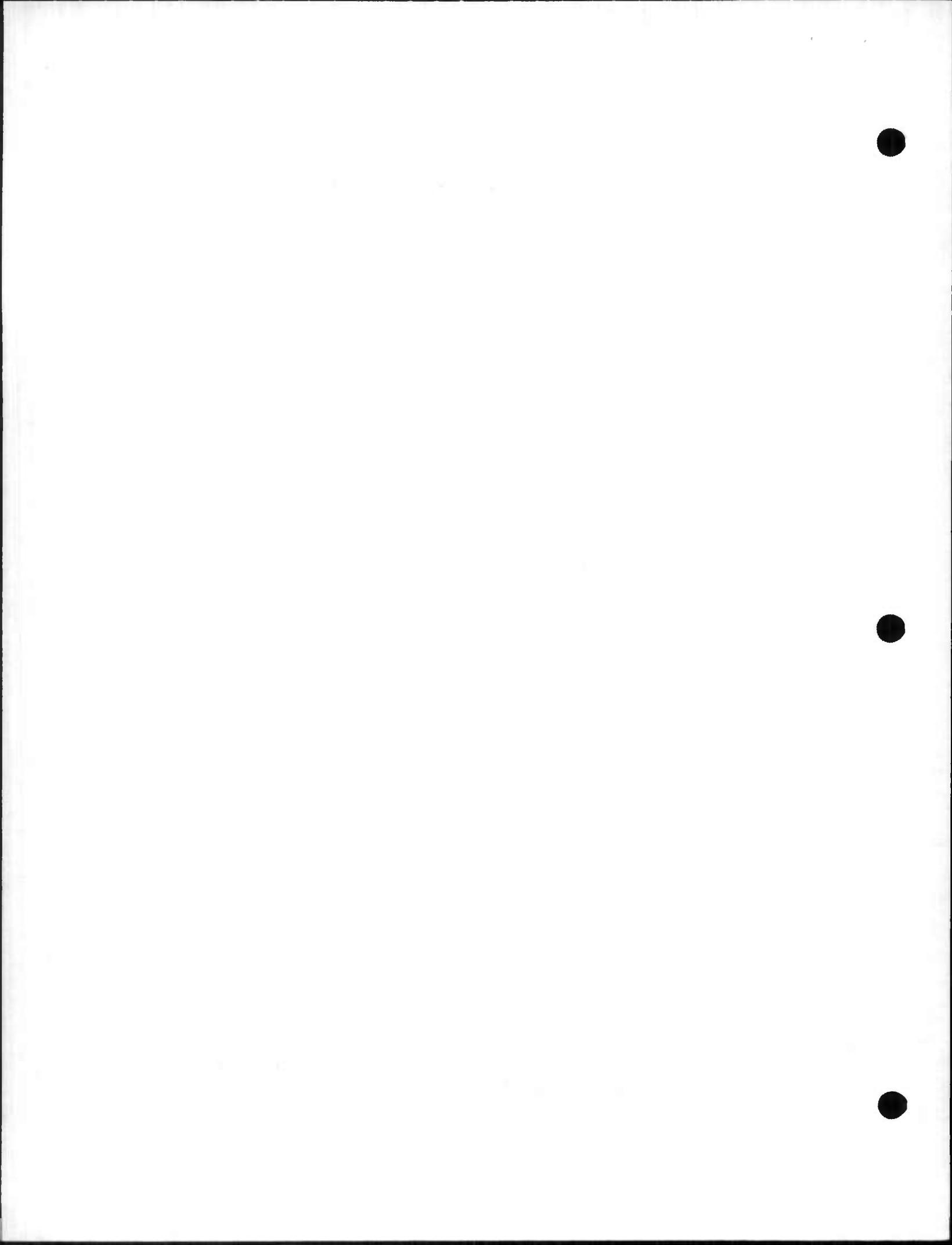
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) ANITA LUIS WINGFIELD										2. DATE OF DEATH MONTH MAY DAY 31 YEAR 1995	3. TIME OF DEATH 0020 A M	
4. SOCIAL SECURITY NUMBER 578-84-2984			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 19 JAN 1959	8. BIRTHPLACE (State or Foreign Country) Prince George's		
9a. FACILITY NAME (If not institution, give street and number) Malcolm Grow Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Camp Springs	9c. COUNTY OF DEATH Prince George's	
10a. STATE N/A		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington D.C.				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 2331 Park Place S.E.						10f. ZIP CODE 20020		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES April 19 1981-				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black		14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel NCOIC				16b. KIND OF BUSINESS/INDUSTRY Government						
17. FATHER'S NAME (First, Middle, Last) Martin Benton										18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Harris		
19a. INFORMANT'S NAME (Type/Print) David Wingfield					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2331 Park Pl. S.E. Washington D.C. 20020							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Arlington National Cem Jun 5 Arlington, Va.					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem Jun 5 Arlington, Va.		DATE 95	20c. LOCATION — City or Town, State J.B. Jenkins Funeral Home				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Juawana S. Braxton										22. NAME AND ADDRESS OF FACILITY 7474 Landover Rd. Landover, Md. 20785		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
s. AMNIOTIC FLUID EMBOLUS DUE TO (OR AS A CONSEQUENCE OF): b. DISSEMINATED INTRAVASCULAR COAGULATION AND SHOCK DUE TO (OR AS A CONSEQUENCE OF): c. OUE TO (OR AS A CONSEQUENCE OF): d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER AL 17128								29d. DATE SIGNED (Month, Day, Year) ► 02 JUNE 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL E COGHLAN, CAPT, USAF, MC										89 MDG 1050 W PERIMETER RD SUITE C1-7 ANDREWS AIR FORCE BASE MD 20331-6600		
31. DATE FILED (Month, Day, Year) JUN 06 1995		32. REGISTRAR'S SIGNATURE John Michael Coglan								DHMH-16 Rev 1/80		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

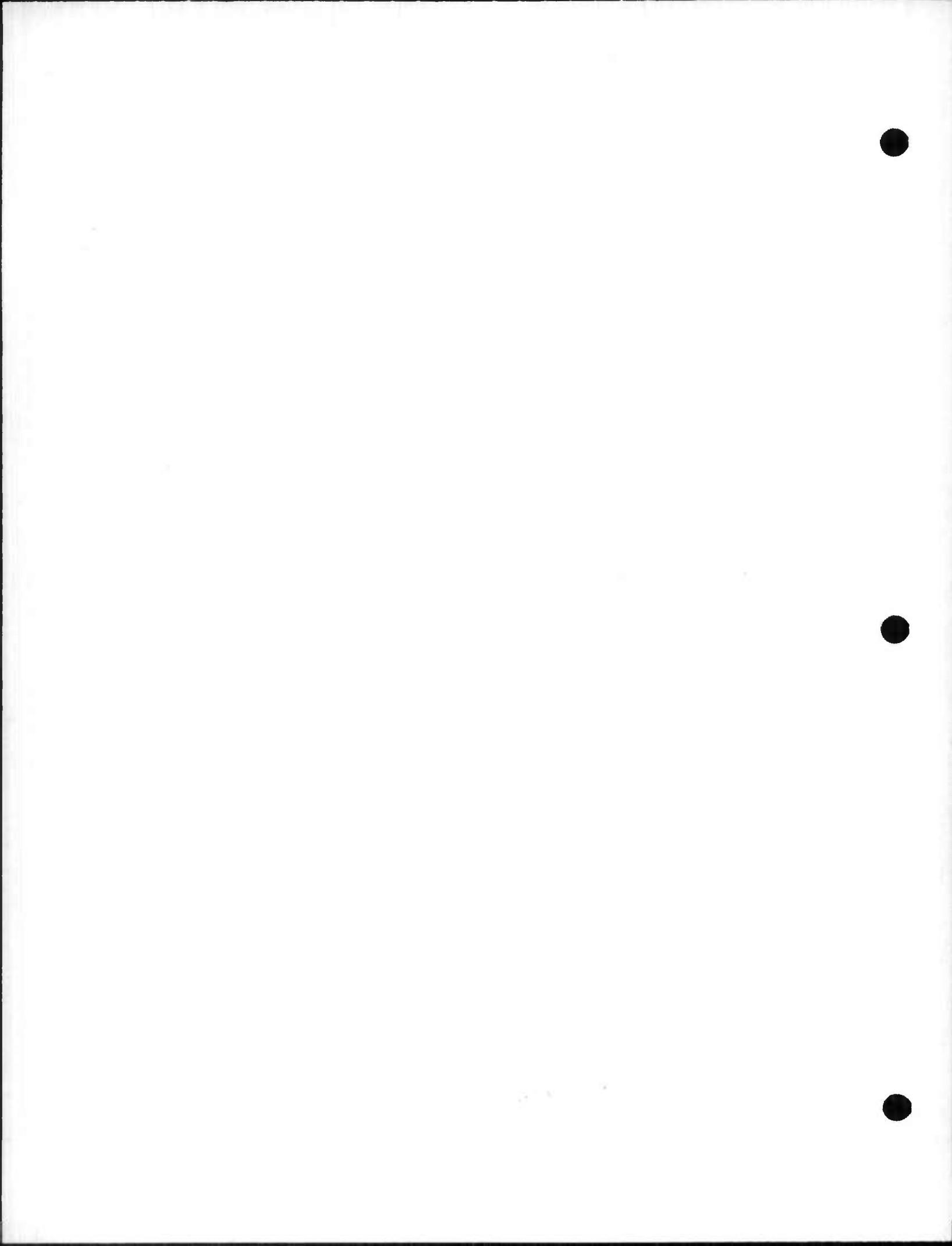
BALTIMORE, MARYLAND 21215-0020

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19218

1. DECEDENT'S NAME (First, Middle, Last) <i>MABEL J. Woods</i>						2. DATE OF DEATH MONTH MAY DAY 31 YEAR 1995	3. TIME OF DEATH 11:18 PM	
4. SOCIAL SECURITY NUMBER 245-12-9982			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1908	8. BIRTHPLACE (State or Foreign Country) Wisacky, SC
9a. FACILITY NAME (If not institution, give street and number) SOUTHERN MARYLAND Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Clinton			9c. COUNTY OF DEATH Prince Georges		
10a. STATE MD			10b. COUNTY Prince Georges			10c. CITY, TOWN OR LOCATION Temple Hills		
10e. STREET AND NUMBER 3400 - 27th Avenue			10f. ZIP CODE 20748			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Domestic		
17. FATHER'S NAME (First, Middle, Last) Henry L. James			18. MOTHER'S NAME (First, Middle, Maiden Surname) Sudie Bradford					
19a. INFORMANT'S NAME (Type/Print) Willie C. Stephens-Swint			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3400-27th Ave. Temple Hills, MD 20748					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Boatwright Funeral Home			DATE 6/5/95	20c. LOCATION — City or Town, State Bishopville, SC	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Julie P. Marshall</i>			22. NAME AND ADDRESS OF FACILITY Marshall's Funeral Home, Inc.					
			4308 Suitland Rd. Suitland, MD 20746					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								
<p>a. <i>Acute Respiratory Insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetic mellitus</i></p> <p>b. <i>Cerebral vascular accident with right side weakness</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Confetti heart failure</i></p> <p>c. <i>Blindness</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Stroke</i></p> <p>d. <i>Stroke</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Stroke</i></p>								
Approximate Interval Between Onset and Death New onset								
May year								
May years								
10 years.								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Blindness						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 20032		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>K. Daniel no</i>			29c. LICENSE NUMBER D 25640			29d. DATE SIGNED (Month, Day, Year) June 2, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) K. Hosznowski David 1328 SOUTHERN AVENUE · WASHINGTON DC								
31. DATE FILED (Month, Day, Year) JUN 06 1995			32. REGISTRAR'S SIGNATURE <i>Jahnie Marshall</i>					



HOSPITAL, OR ATTENDING PHYSICIAN. This law requires that this certificate be executed without delay after the death of the patient. It should be retained by the attending physician or attending physician, or by the hospital director. After this certificate has been signed by the attending physician or by the hospital director, it should be forwarded to the funeral director. The funeral director should then forward it to the mortician.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN "MEDICAL CERTIFICATION"

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: In law requires that the death certificate be executed within 24 hours after death.

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

TO BE COMPETED BY EINNEBAL DIRECTOR

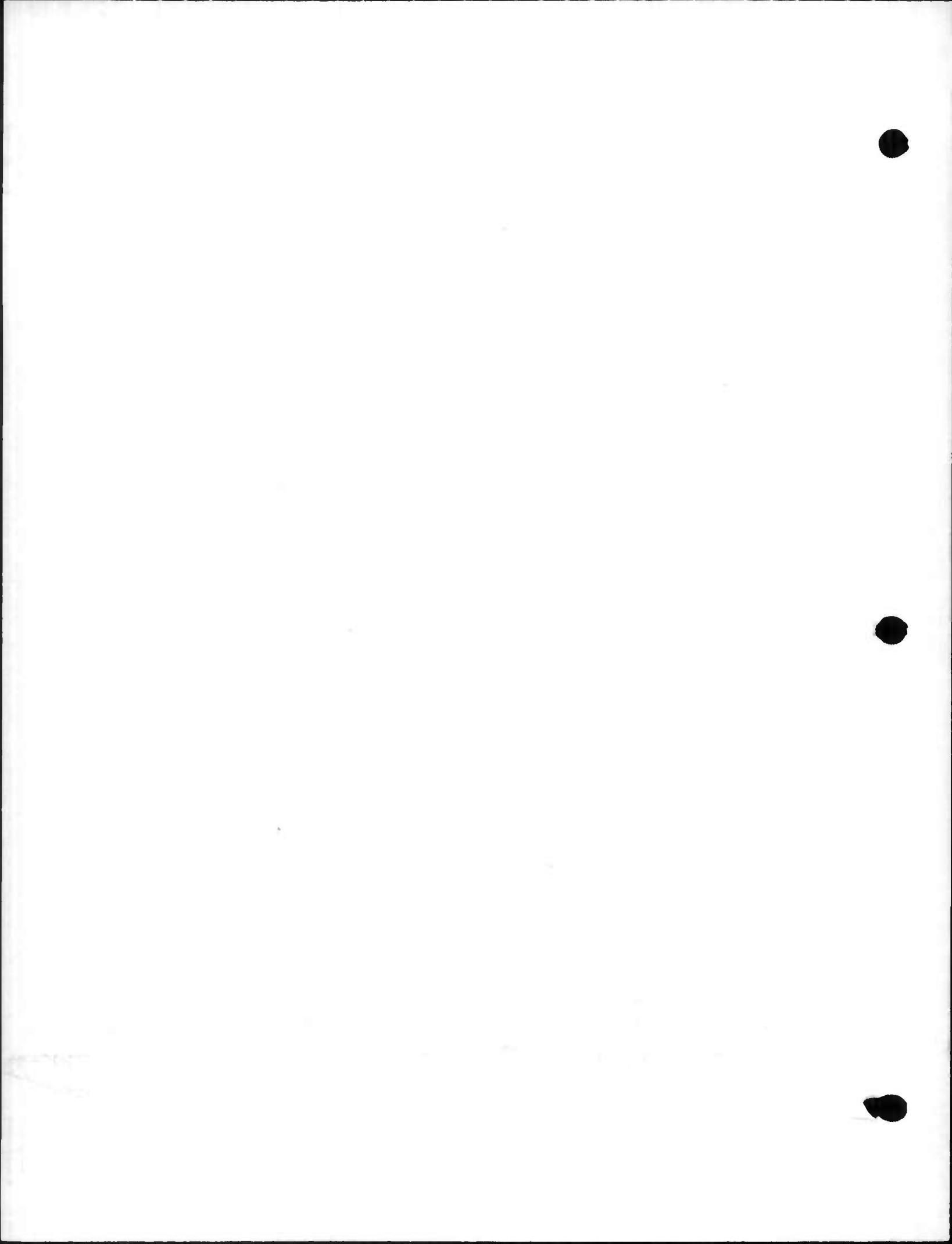
1 - FOR
STATE
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG NO

95 19219

1. DECEDENT'S NAME (First, Middle, Last) <i>Grace Watson</i>				2. DATE OF DEATH MONTH DAY YEAR <i>June 1, 1995</i>	3. TIME OF DEATH <i>6:32 A.M.</i>	
4. SOCIAL SECURITY NUMBER <i>578-44-4756</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>77 YRS.</i>	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <i>0 0 0 0</i>	7. DATE OF BIRTH (Month, Day, Year) <i>May 13, 1918</i>	8. BIRTHPLACE (State or Foreign Country) <i>Conway, Miss.</i>
9a. FACILITY NAME (If not institution, give street and number) <i>Prince George's Community Hosp.</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Cheverly, MD</i>		9c. COUNTY OF DEATH <i>Prince George's</i>
10a. STATE <i>MD</i>		10b. COUNTY <i>Prince George's</i>		10c. CITY, TOWN OR LOCATION <i>Seat Pleasant</i>		
10a. STREET AND NUMBER <i>519 68th Street</i>				10f. ZIP CODE <i>20743</i>	10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES <i>College (1-4 or 5+)</i>		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <i>Black</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i>		16b. KIND OF BUSINESS/INDUSTRY <i>DC Public Schools</i>		
17. MOTHER'S NAME (First, Middle, Last) <i>Hezekiah Watson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Jennie R. Spikes</i>		
19a. INFORMANT'S NAME (Type/Print) <i>Michael Watson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2022 Baltimore Rd Apt. L43 Rockville, MD 20851</i>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other <i>(Specify)</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Fort LINCOLN Cemetery</i>		DATE <i>6/6/95</i>	20c. LOCATION — City or Town, State <i>Bladensburg, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tyrone J. Young</i>				22. NAME AND ADDRESS OF FACILITY <i>Tyrone J. Young Funeral Services 5635 Eads Street, N.E., Wash., DC 20019</i>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Recurrent breast cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>{</i> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <i>1 year</i>						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <i>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide</i>		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M <i>M</i>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i></i>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i></i>		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert P. Rodriguez MD</i>				LICENSE NUMBER <i>D21230</i>	29c. DATE SIGNED (Month, Day, Year) <i>June 2, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert P. Rodriguez MD, 5009 Rayburn Ct. Op 8th Md 20745</i>						
31. DATE FILED (Month, Day, Year) <i>JUN 07 1995</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson Russell</i>				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

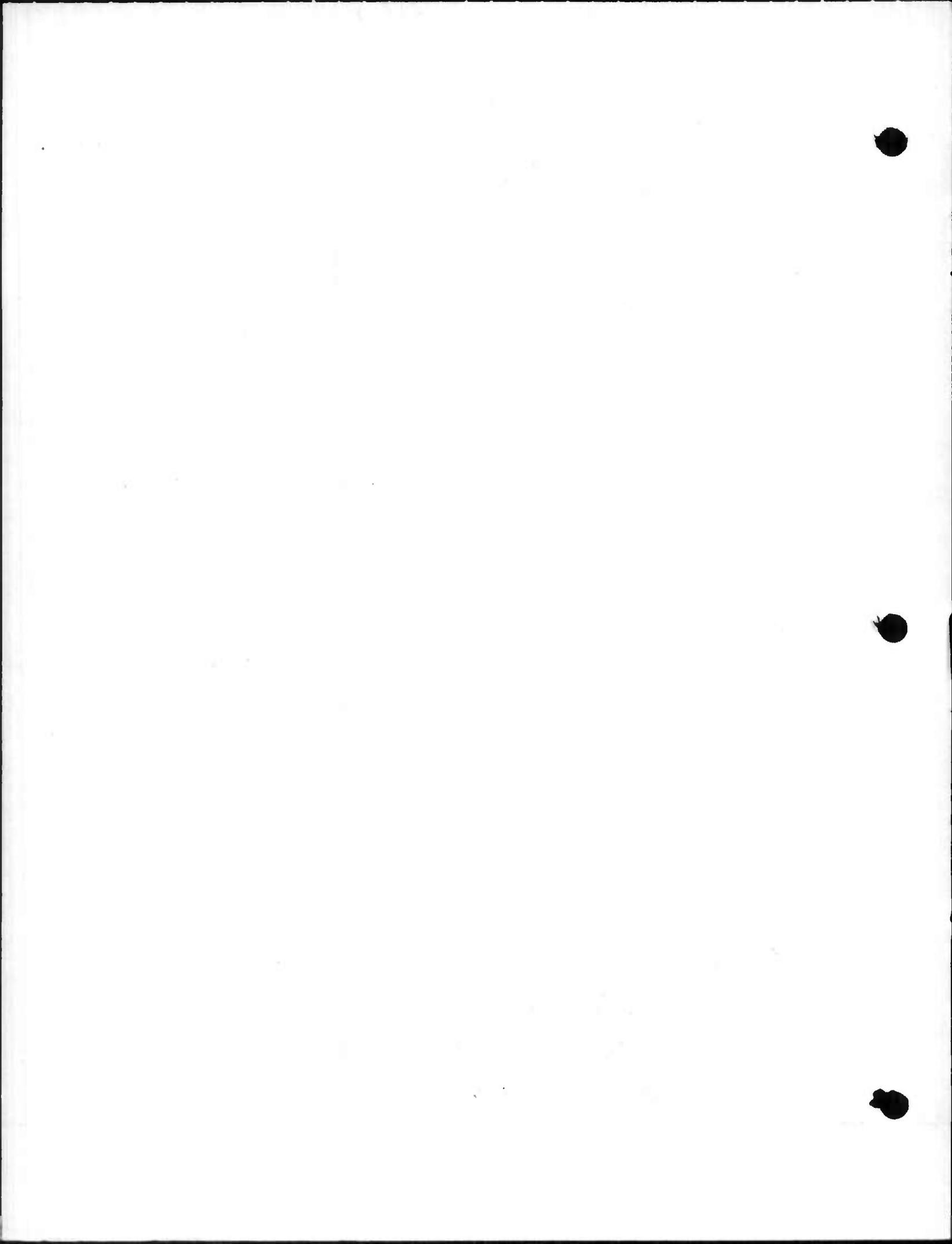
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH 4:35 A.M.			
Melvin Arnold WINKELMAN		June 5, 1995											
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 MRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
463 62 5728		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		61 YRS.		MONTHS		DAYS		HOURS		MIN.	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH								9c. COUNTY OF DEATH			
Doctors' Community Hospital		Lanham								Prince George's			
RESIDENCE OF DECEASED													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
Maryland		Prince George's		Bowie									
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?			
12304 Rambling Lane		20715								United States			
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 12		College (1-4 or 8+) Police Officer				Metropolitan Police Dept.							
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)											
Walter Winkelman		Frances Keike											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Beatrice Smith Winkelman		12304 Rambling Lane Bowie Maryland 20715											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE				20c. LOCATION — City or Town, State			
		Metropolitan Crematory 6/6/95								Alexandria Virginia			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Evans, P.A.</i>		22. NAME AND ADDRESS OF FACILITY Robert E. Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Md. 20715											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Approximate Interval Between Onset and Death											
a. Severe Ischemic Cardiomyopathy, LVEF 10-20% DUE TO (OR AS A CONSEQUENCE OF):		1 yr											
b. CAD ASHD, Dialysis, Hypertensive Stt DUE TO (OR AS A CONSEQUENCE OF):		10-15 yrs											
c. Dialysis, ASHD, Pneumonia, G.I. Bleed. DUE TO (OR AS A CONSEQUENCE OF):		1 wk											
d. CRF i Dialy		15 yrs											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)											
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29g. LICENSE NUMBER D 33483		29d. DATE SIGNED (Month, Day, Year) ► 6/5/95							
29h. SIGNATURE AND TITLE OF CERTIFIER <i>Pratibha Srivastava, MD</i>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) P. SRIVASTAVA, MD, 9801 Greenbelt Rd # 212 Lanham MD 20706													
31. DATE FILED (Month, Day, Year) JUN 07 1995		32. REGISTRAR'S SIGNATURE <i>Julia Shuler Raskin</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

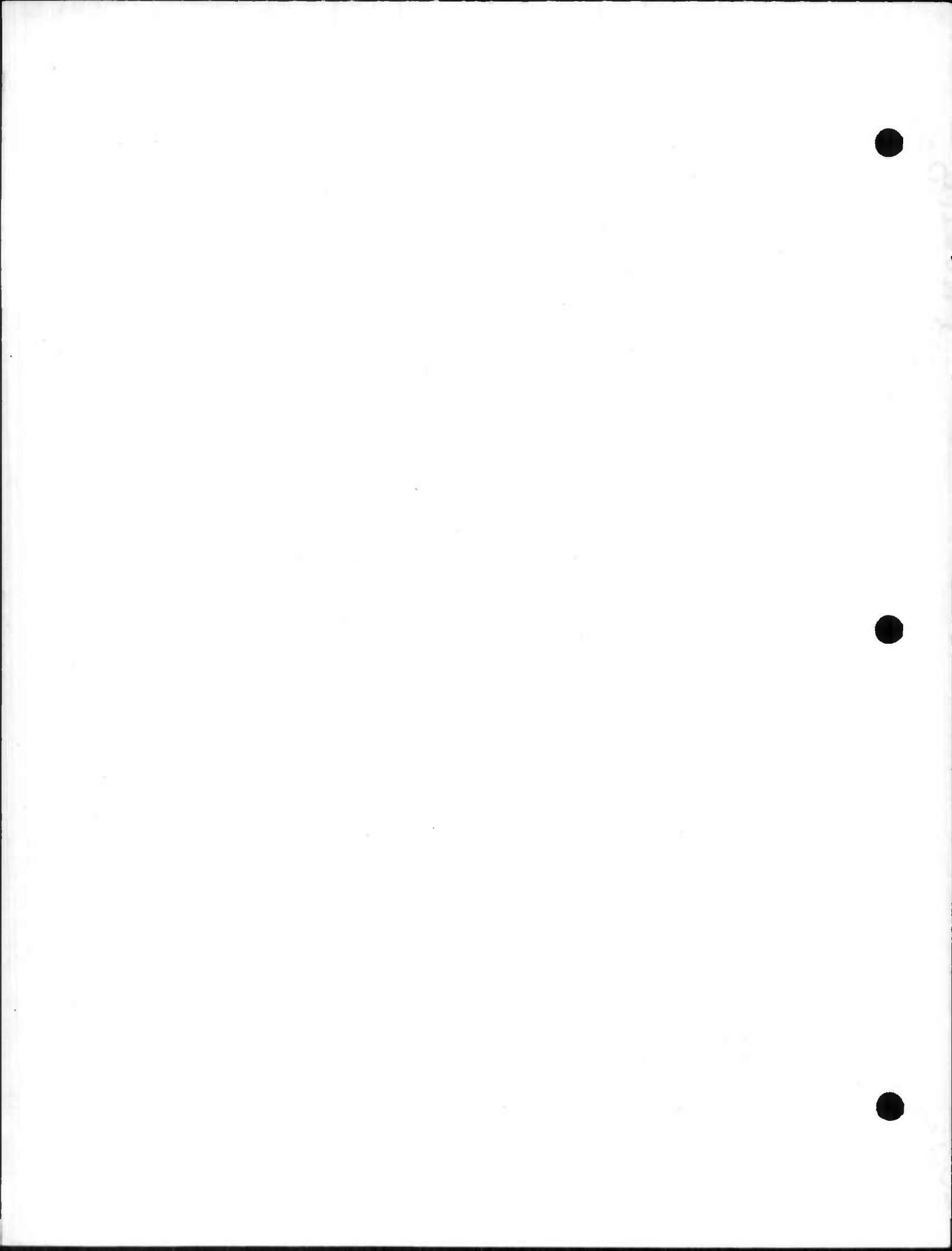
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1 - FOR STATE REGISTRAR														
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH	3. TIME OF DEATH		
JAMES FRANKLIN WATHEN											MONTH JUNE 3 1995 YEAR	10:02 PM M		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)						
212-26-8102		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	67 YRS.	MONTHS	DAYS	HOURS	MIN.	Dec. 7, 1927		Maryland				
9a. FACILITY NAME (If not institution, give street and number)											9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
ST. MARY'S NURSING CENTER											LEONARDTOWN		ST. MARY'S	
RESIDENCE OF DECEDENT														
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?						
				Washington, D. C.				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER					10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?						
1910 - 21st Place, S. E.					20020			U.S.A.						
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. RACE — American Indian, Black, White, etc. Specify: White						
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced					1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY									
Elementary/Secondary (0-12) 8		College (1-4 or 5+) Driver			Frank Parsons Paper Co.									
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Parran Wathen					Estelle Payne									
19a. INFORMANT'S NAME (Type/Print)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Peter A. Wathen					11415 Meathe Dr. Fairfax, Virginia 22030									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place)			DATE		20c. LOCATION — City or Town, State				
					Cedar Hill Cemetery			6/7/95		Suitland, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George P. Kalas</i>					22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745									
23. PART I. Enter the disease(s), or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) a. <i>Hypertensive Prostate Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): <i>with</i>														
b. DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hyperglycemia</i>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER <i>JAMES C. BOYD, MD</i>					29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year)						
					D19917			► JUNE 4, 1995						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
JAMES C. BOYD, MD, 17 JEFFERSON STREET, LEONARDTOWN, MARYLAND 20650														
31. DATE FILED (Month, Day, Year) <i>JUN 6 1995</i>		32. REGISTRAR'S SIGNATURE <i>S. Jackson Randall</i>												



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

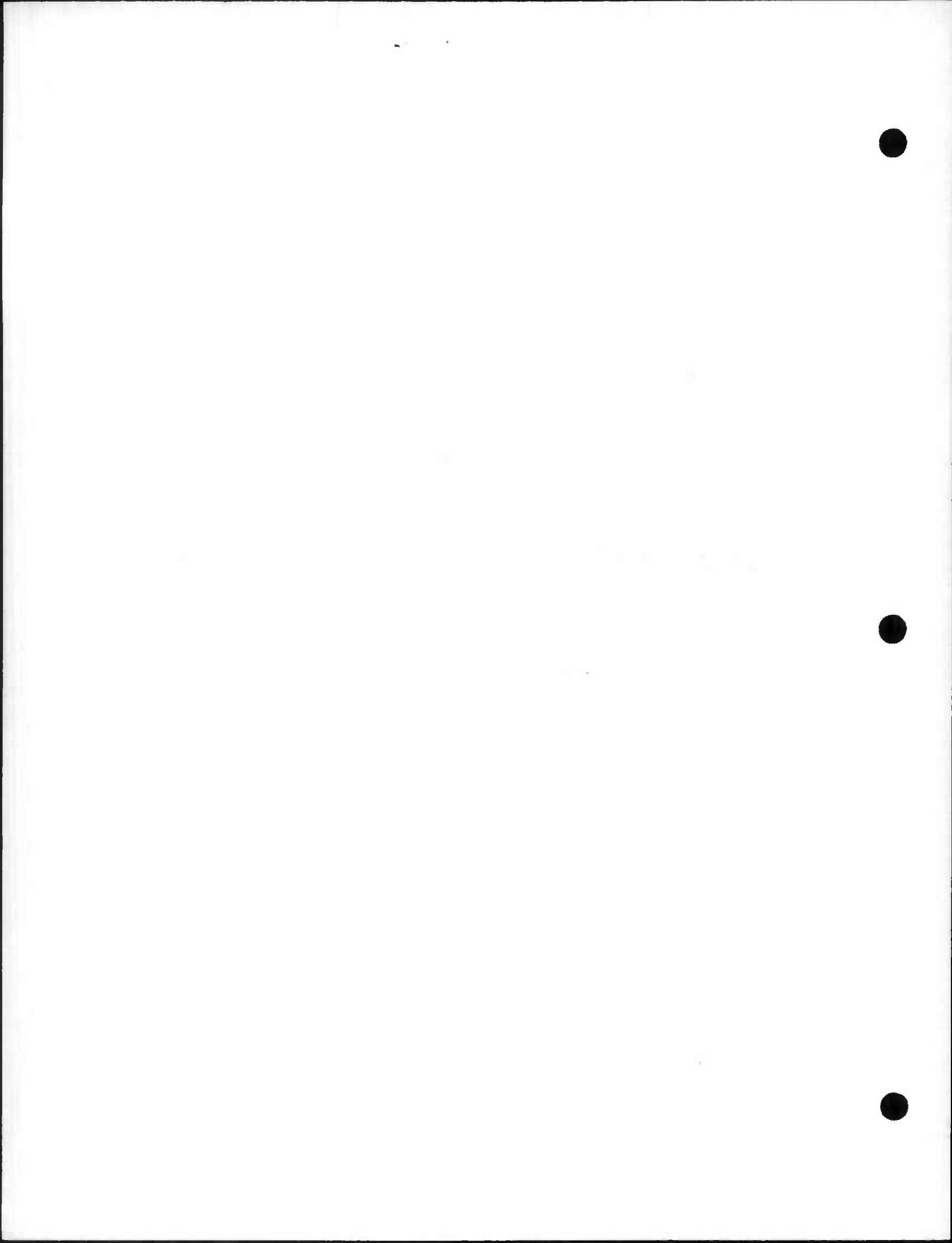
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Josie Edna Weaber													
4. SOCIAL SECURITY NUMBER 217-80-9518 5. SEX M <input checked="" type="checkbox"/> F 6. AGE (In yrs. last birthday) YRS. 7. DATE OF BIRTHN (Month, Day, Year) June 26, 1912												2. DATE OF DEATH MONTH JUNE DAY 10 YEAR 1995	3. TIME OF DEATH 2:50 PM
8a. FACILITY NAME (If not institution, give street and number) Southern Maryland Hospital												8b. CITY, TOWN OR LOCATION OF DEATH Clinton	8c. COUNTY OF DEATH Prince George's
10a. STATE Maryland 10b. COUNTY Charles 10c. CITY, TOWN OR LOCATION Waldorf												10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12110 Hintze Place 10f. ZIP CODE 20601												10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) George Baber												18. MOTNER'S NAME (First, Middle, Maiden Surname) Mary Eubanks	
19a. INFORMANT'S NAME (Type/Print) James L. Weaber												19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 811 Louise Drive, Weaver, Alabama 36277	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Trinity Memorial Gardens				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE	20c. LOCATION — City or Town, State 6-14 Waldorf, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ben Julian Matthews M00658								22. NAME AND ADDRESS OF FACILITY Huntt Funeral Home, Inc. P. O. Box 156, Waldorf, MD 20604-0156					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Approximate Interval Between Onset and Death	
a. Respiratory Failure <small>DUE TO (OR AS A CONSEQUENCE OF):</small>												3 day	
b. Chronic Obstructive Pulmonary Disease <small>DUE TO (OR AS A CONSEQUENCE OF):</small>												Year	
c. Atherosclerotic Cardiovascular Disease <small>DUE TO (OR AS A CONSEQUENCE OF):</small>												Year	
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 7 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 												29c. LICENSE NUMBER DO 1923	29d. DATE SIGNED (Month, Day, Year) 11 June 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T.L. Sheldon M.D. Brandywine, MD 20663													
31. DATE FILED (Month, Day, Year) JUN 13 1995												32. REGISTRAR'S SIGNATURE 	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

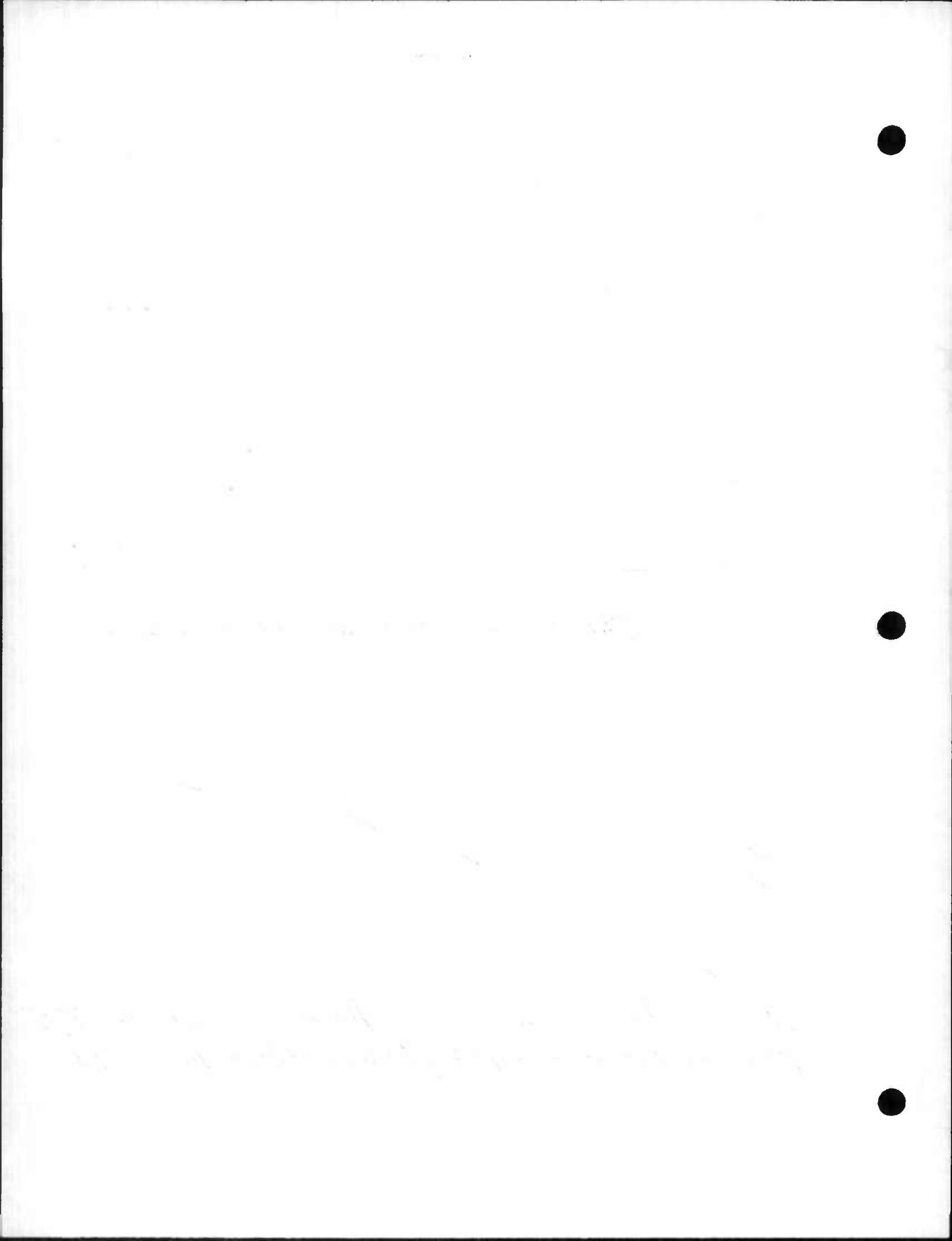
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.													
1 - FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR June 11, 1995									3. TIME OF DEATH 10:30 p.m.													
1. DECEDENT'S NAME (First, Middle, Last) Arlene Elizabeth Whitmore												4. SOCIAL SECURITY NUMBER 378-14-6082		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		9. DATE OF BIRTHN (Month, Day, Year) May 23, 1916		10. BIRTHPLACE (State or Foreign Country) Kalamazoo, MI	
9a. FACILITY NAME (If not institution, give street and number) Larkin Chase Nursing Center												9b. CITY, TOWN OR LOCATION OF DEATH Bowie		9c. COUNTY OF DEATH Prince George's											
RESIDENCE OF DECEDENT												10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Lothian		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 89 B Berts Drive		10f. ZIP CODE 20711		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES N/A		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Caucasian		14. RACE — American Indian, Black, White, etc. Specify: Caucasian																			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home																					
17. FATHER'S NAME (First, Middle, Last) Albert Jickling		18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie L. Upson		19a. INFORMANT'S NAME (Type/Print) Onalee Richards		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 89 B Berts Drive Lothian Md. 20711		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) National Memorial Park		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) June 14, 1995		20c. LOCATION — City or Town, State Falls Church, Virginia		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Lee Funeral Home, Inc. 6633 Old Alexandria Ferry Rd Clinton, Md 20735									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												24. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Artungoletic cardiovascular disease													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Artungoletic cardiovascular disease												DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST																									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED													
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																					
29b. SIGNATURE AND TITLE OF CERTIFIER Augusto Rodriguez MD		29c. LICENSE NUMBER D 21230		29d. DATE SIGNED (Month, Day, Year) June 12, 1995																					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Augusto P. Rodriguez MD, 5009 Rayburn Ct. Clinton, Md 20748		31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE Jahn Anderson-Randall																					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

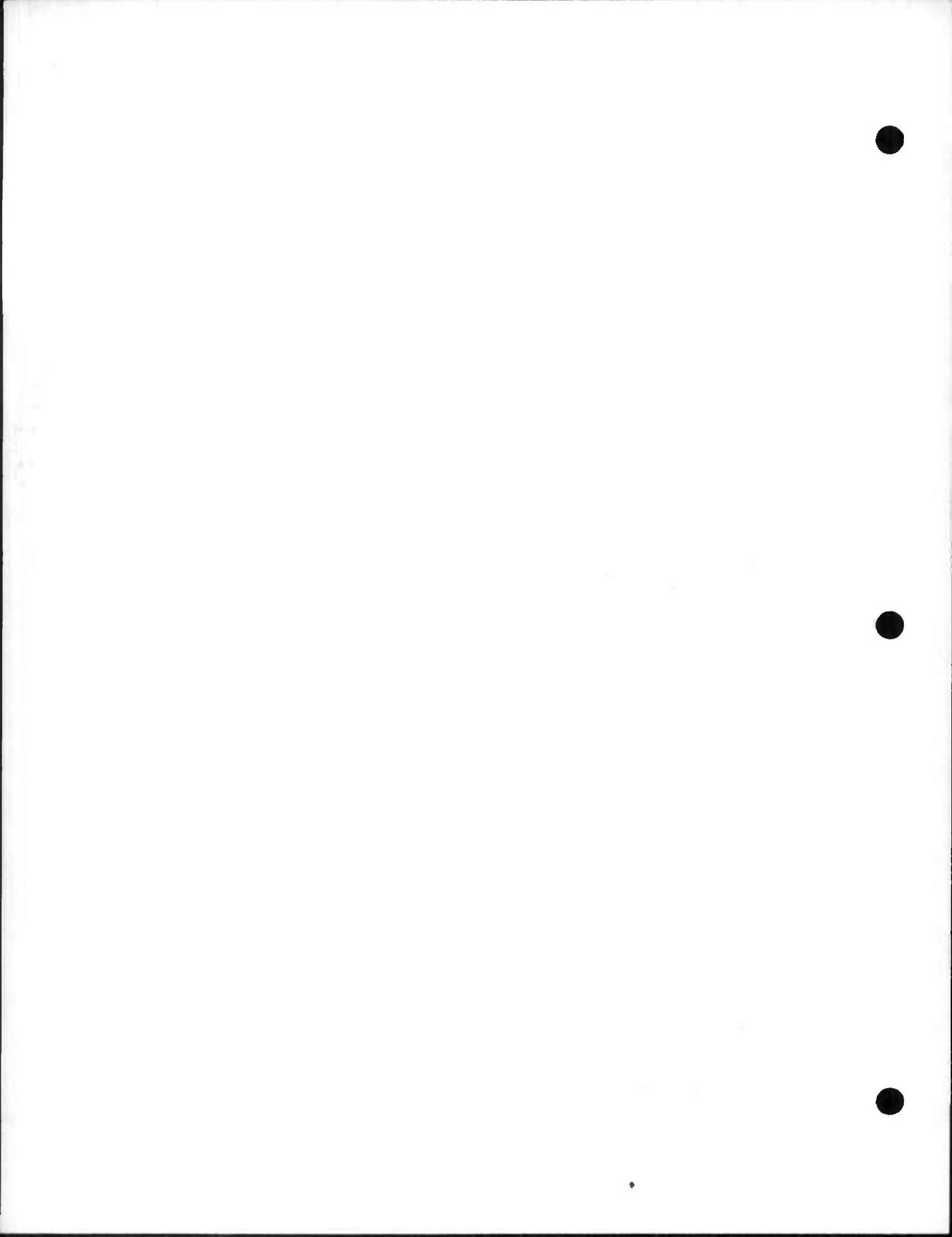
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)		Grace Beulah WACHTER								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. less birthday) 84 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) Mar 24, 1911		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH Frederick								9c. COUNTY OF DEATH Frederick		
RESIDENCE OF DECEDENT												
10e. STATE Maryland	10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 990 Waterford Drive					10f. ZIP CODE 21702				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Robert Joshua CARTY					18. MOTHER'S NAME (First, Middle, Maiden Surname) Vernie Sophia GRAMS							
19e. INFORMANT'S NAME (Type/Print) Mrs. Dawn Hawes					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Ore Mill Place, Thurmont, Maryland 21788							
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, cemetery or other place) Mt. Olivet Cemetery Jun 14, 1995			DATE		20c. LOCATION — City or Town, State Frederick, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Keith Lynn Lobensent</i>					22. NAME AND ADDRESS OF FACILITY Keeney & Basford P.A. Funeral Home 106 East Church Street, Frederick, MD 21701							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Malignant Melanoma</i>												
Approximate Interval Between Onset and Death 3-4 mos												
a. DUE TO (OR AS A CONSEQUENCE OF):												
b. DUE TO (OR AS A CONSEQUENCE OF):												
c. DUE TO (OR AS A CONSEQUENCE OF):												
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24e. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allen J. Gilson, M.D., 1475 Taney Avenue, Ste. 204, Frederick, Maryland 21702		32. REGISTRAR'S SIGNATURE <i>Jeanne Davidsohn Harrell</i>				29c. LICENSE NUMBER D26516				29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995		
31. DATE FILED (Month, Day, Year) JUN 12 1995												



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or if Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		ETHEL AMELIA WHITEHILL				2. DATE OF DEATH		3. TIME OF DEATH	
4. SOCIAL SECURITY 217-12-2410 217-32-7414		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		MONTH June DAY 7, 1995 YEAR		9:00 A M	
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frederick				7. DATE OF BIRTH (Month, Day, Year) Feb. 16, 1907			
9c. COUNTY OF DEATH Frederick		8. BIRTHPLACE (State or Foreign Country) Maryland							
10a. STATE Maryland		10b. COUNTY Frederick	10c. CITY, TOWN OR LOCATION Frederick				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 200 Rockwell Terrace		10f. ZIP CODE 21701				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Federal Government		16b. KIND OF BUSINESS/INDUSTRY None					
17. FATHER'S NAME (First, Middle, Last) Maurice W. Baker		18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude A. Unknown							
19a. INFORMANT'S NAME (Type/Print) Mr. David Weinberg		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15 North Court Street, Frederick, Maryland 21701							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, cemetery or other place) Mount Olivet Cemetery		DATE 6/9		20c. LOCATION — City or Town, State Frederick, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY ROBERT E. DAILEY & SON FUNERAL HOMES, P.A. 1201 NORTH MARKET ST. FREDERICK, MD 21701							
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute cerebral hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death 12 hours			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. _____ DUE TO (OR AS A CONSEQUENCE OF):	c. _____ DUE TO (OR AS A CONSEQUENCE OF):	d. _____					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension, pernicious anemia</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D35183				29d. DATE SIGNED (Month, Day, Year) ► June 8, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ali James Afrookteh MD 300 West Ninth Street Frederick, Maryland 21701									
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 							

1000 0000 0000 0000

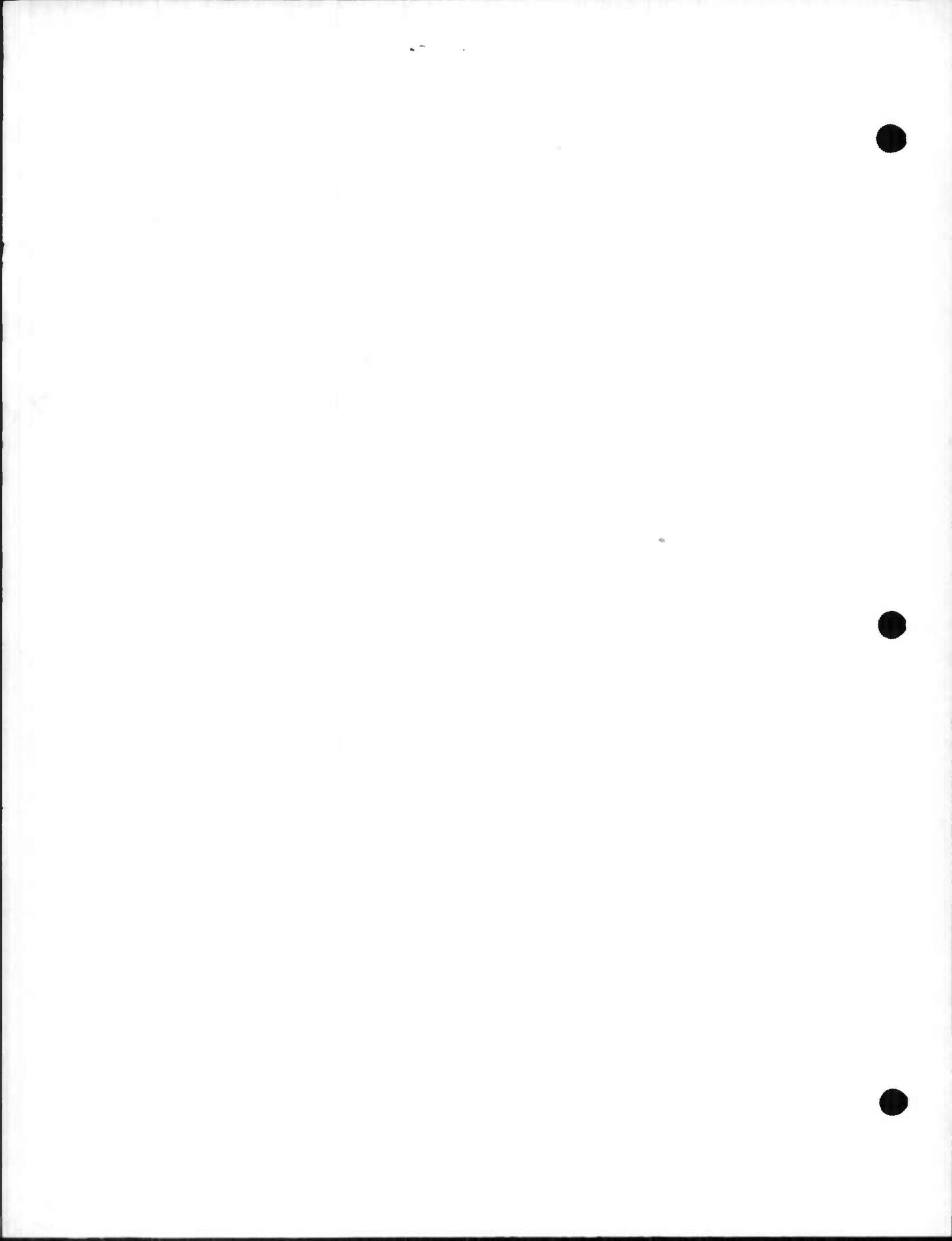
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		George Robert Wilson, Sr.						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 7:36 P.M.			
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH Month Day Year Feb. 11, 1914		8. BIRTHPLACE (State or Foreign Country) PA.			
9a. FACILITY NAME (If not institution, give street and number)		Physicians Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH La Plata		9c. COUNTY OF DEATH Charles			
10a. STATE MD		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION LaPlata						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 511 Linden Lane								10f. ZIP CODE 20646		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 3				16b. KIND OF BUSINESS/INDUSTRY Automobile Dealer Mgr.				Automobile			
17. FATHER'S NAME (First, Middle, Last) Harry Wentworth Wilson								18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Blair Wilson					
19a. INFORMANT'S NAME (Type/Print) George R. Wilson, Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 704 Silver Linden Dr. LaPlata, MD 20646											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Facility) Metropolitan Crem. 6/14/95						DATE 6/14/95		20c. LOCATION — City or Town, State Alexandria, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David C. Echols</i>		22. NAME AND ADDRESS OF FACILITY AREHART-ECHOLS FUNERAL HOME, INC. P.O. Box 567 LaPlata, MD 20646											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cancer Pulmonary Arter</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Pulmonary Embolism</i>													
b. <i>Cancer Prostate</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Cancer Prostate</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Cancer Prostate</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cancer Prostate</i>													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Henry L. Burke, M.D.</i>		29c. LICENSE NUMBER D-01009		29d. DATE SIGNED (Month, Day, Year) ► 6-12-95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Henry L. Burke, M.D.		115-A LaGrange Avenue, P.O. Box 591 La Plata, Maryland 20646											
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>		DHMH-16 Rev 1/99									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10

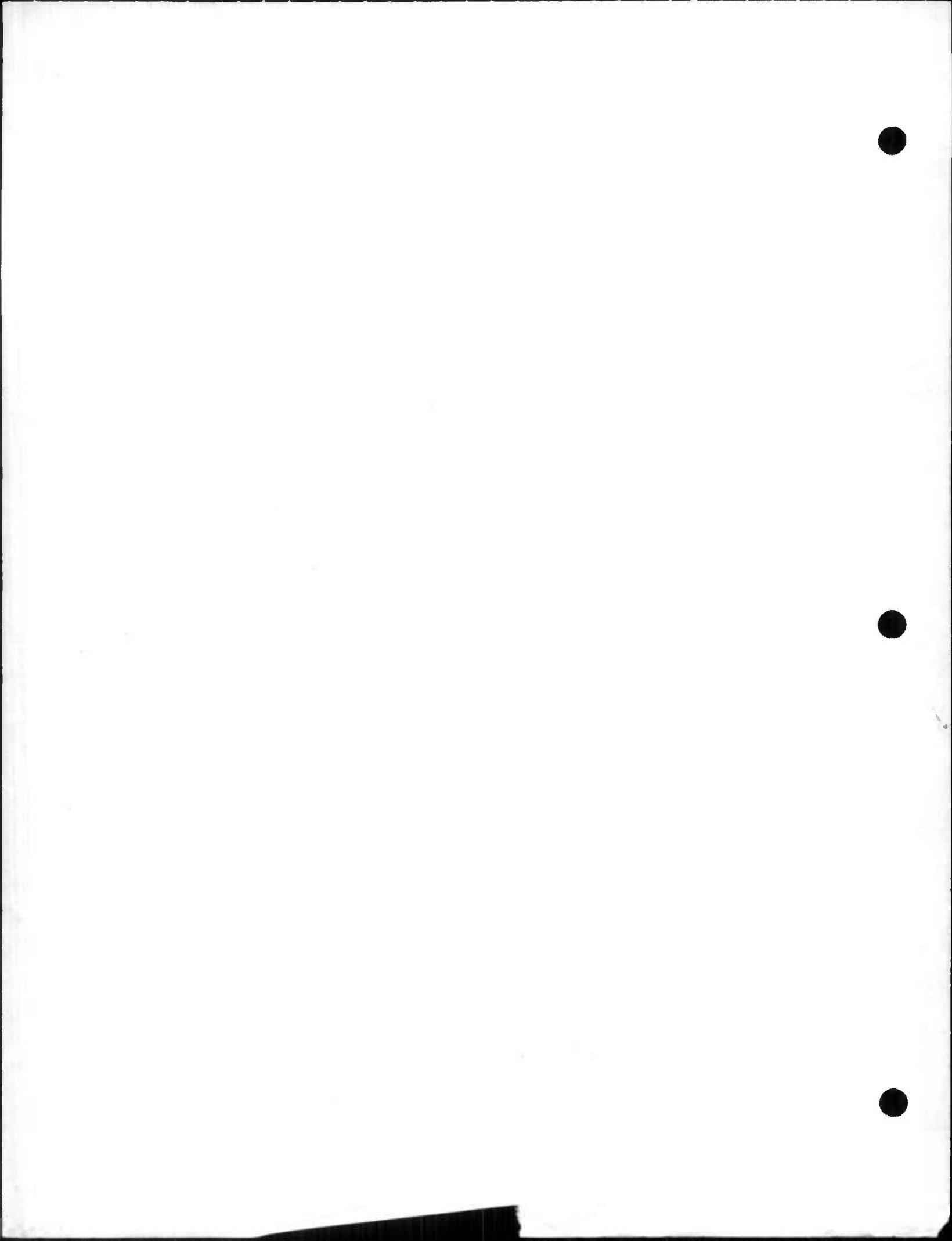
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19227

1. DECEASED'S NAME (First, Middle, Last) MARY J. YATES						2. DATE OF DEATH MONTH JUNE DAY 3 YEAR 1995	3. TIME OF DEATH 7:30p M
4. SOCIAL SECURITY NUMBER 216-12-4578		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 26, 1920	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Washington Adventist Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Takoma Park		9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEASED							
10a. STATE Maryland	10b. COUNTY Prince Georges	10c. CITY, TOWN OR LOCATION Laurel				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 15613 Dorset Road				10f. ZIP CODE 20707		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Lab Technician			16b. KIND OF BUSINESS/INDUSTRY Dept. of Agriculture		
17. FATHER'S NAME (First, Middle, Last) Andrew Yates				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Bond			
19a. INFORMANT'S NAME (Type/Print) Grace Jackson (Sister)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1011 Turney Ave., Laurel, MD 20707			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Md. Nat'l Mem. Park		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. Nat'l Mem. Park			DATE 6/9	20c. LOCATION — City or Town, State Laurel, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SNOWDEN FUNERAL HOME, P.A. ROCKVILLE, MD 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LOW CARDIAC OUTPUT							
DUE TO (OR AS A CONSEQUENCE OF): b. AND SEVERE VENTRICULAR ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): c. POOR LEFT VENTRICULAR FUNCTION DUE TO (OR AS A CONSEQUENCE OF): d. AND PULMONARY EDEMA							
Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MITRAL VALVE & CORONARY ARTERY DISEASE MITRAL & CORONARY SURGERY							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 10 <input type="checkbox"/> 11 <input type="checkbox"/> 12 <input type="checkbox"/> 13 <input type="checkbox"/> 14 <input type="checkbox"/> 15 <input type="checkbox"/> 16 <input type="checkbox"/> 17 <input type="checkbox"/> 18 <input type="checkbox"/> 19 <input type="checkbox"/> 20 <input type="checkbox"/> 21 <input type="checkbox"/> 22 <input type="checkbox"/> 23 <input type="checkbox"/> 24 <input type="checkbox"/> 25 <input type="checkbox"/> 26 <input type="checkbox"/> 27 <input type="checkbox"/> 28 <input type="checkbox"/> 29 <input type="checkbox"/> 30 <input type="checkbox"/> 31 <input type="checkbox"/> 32 <input type="checkbox"/> 33 <input type="checkbox"/> 34 <input type="checkbox"/> 35 <input 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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

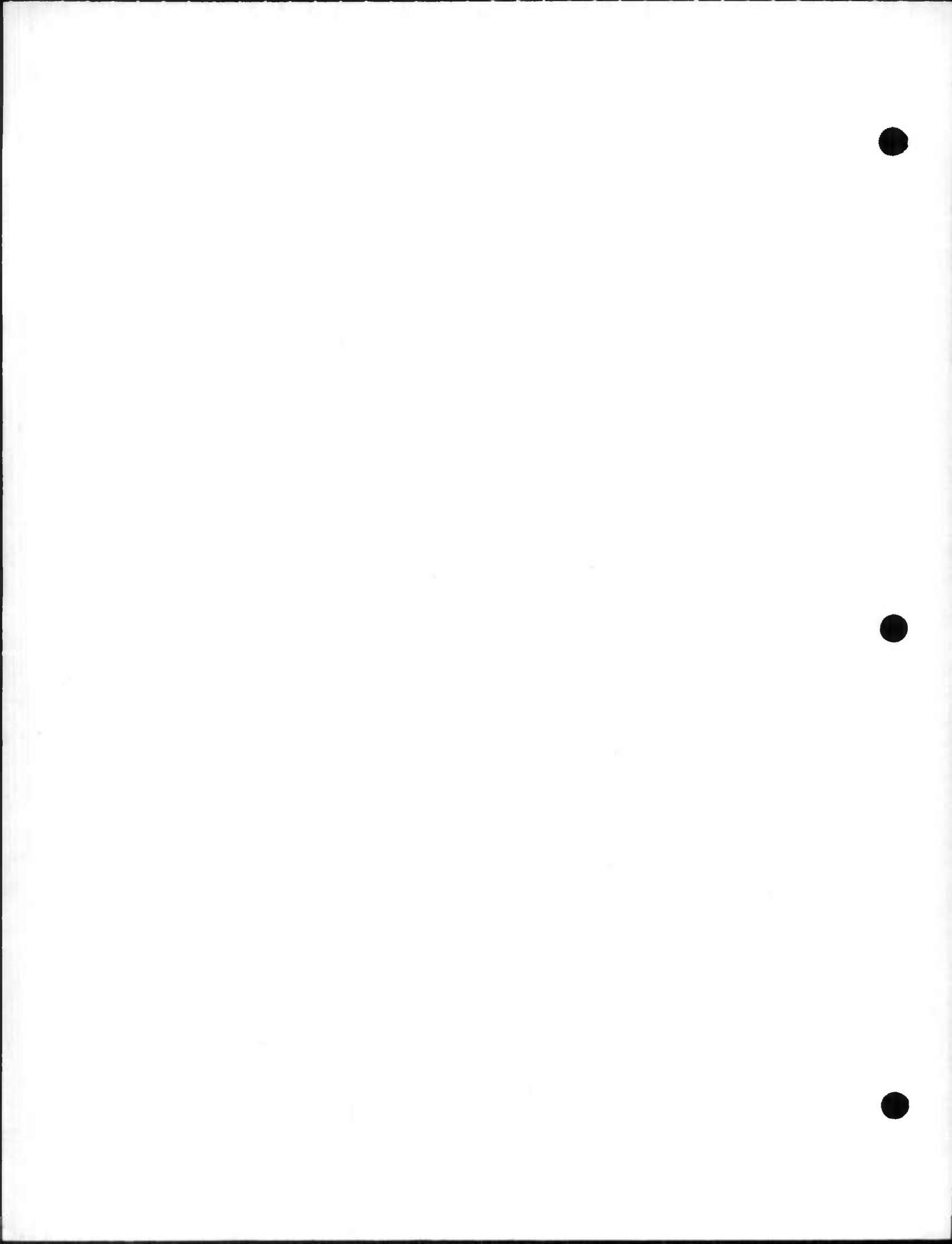
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.				
							2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 5.30PM M					
1. DECEDENT'S NAME (First, Middle, Last) KOUN YIM							4. SOCIAL SECURITY NUMBER 577-13-3743	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 9, 1942	8. BIRTHPLACE (State or Foreign Country) Cambodia
9a. FACILITY NAME (If not institution, give street and number) Prince George's Hospital							9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's				
RESIDENCE OF DECEDENT							10a. STATE Maryland		10b. COUNTY Prince George's	10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5310 Hamilton Street #1							10f. ZIP CODE 20781		10g. CITIZEN OF WHAT COUNTRY? Cambodia				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Oriental					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home								
17. FATHER'S NAME (First, Middle, Last) (UNKNOWN)							18. MOTHER'S NAME (First, Middle, Maiden Surname) (UNKNOWN)						
19a. INFORMANT'S NAME (Type/Print) Vance Khut							19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5310 Hamilton Street, Hyattsville, Maryland 20781						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory			DATE 6/7/95	20c. LOCATION — City or Town, State Alexandria, Virginia						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles F. Beeg J							22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →							Approximate Interval Onset and Death Acute						
a. CEREBRAL VASCULAR Accident DUE TO (OR AS A CONSEQUENCE OF): Coronary Artery Disease													
b. THROMBO-EMBOLISM FROM LEFT VENTRICLE Atrial DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSIVE CARDIOVASCULAR Disease													
c. CHRONIC													
d. CHRONIC													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 24712		29d. DATE SIGNED (Month, Day, Year) ► 6/6/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joseph R. Robinson MD 105-74 LAKE ARBOR Way Mitchellville, MD 20721		32. REGISTRAR'S SIGNATURE John A. Walker, R.R.D.											
31. DATE FILED (Month, Day, Year) JUN 08 1995													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

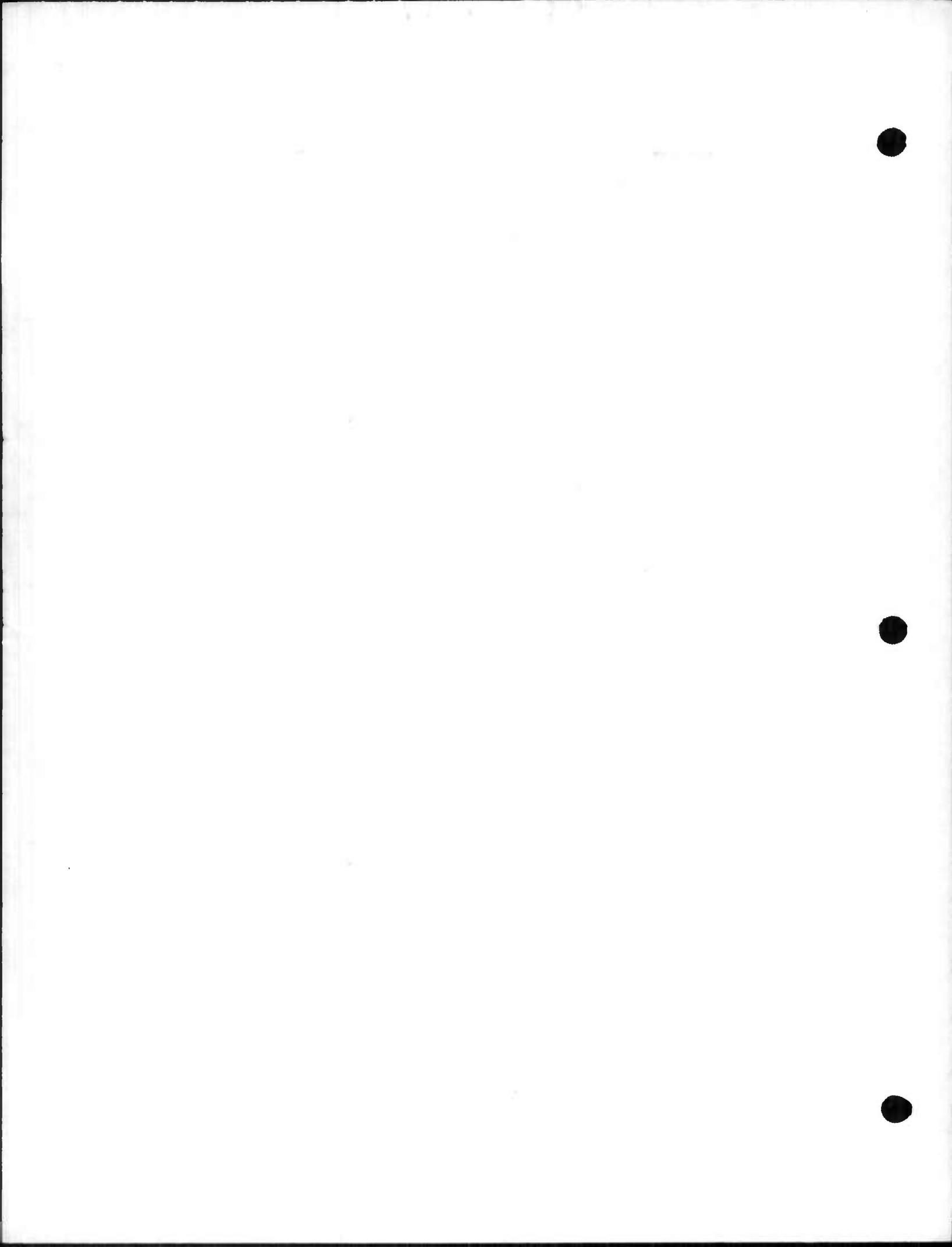
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last) Hector Luis Zarate										2. DATE OF DEATH MONTH May	DAY 24	YEAR 1995	3. TIME OF DEATH 6:20 P M
4. SOCIAL SECURITY NUMBER 581-88-1319		5. SEX XX	6. AGE (In yrs. last birthday) 49	7. IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF HRS. 0	MIN. 0	7. DATE OF BIRTH (Month, Day, Year) July 28, 1945		8. BIRTHPLACE (State or Foreign Country) Puerto Rico			
9a. FACILITY NAME (If not institution, give street and number) 9373 Bremerton Way		9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg								9c. COUNTY OF DEATH Montgomery			
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 9373 Bremerton Way		10f. ZIP CODE 20879								10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: Puerto Rico				14. RACE — American Indian, Black, White, etc. Specify:					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Technician			16b. KIND OF BUSINESS/INDUSTRY D.C. Medical Examiners								
17. FATHER'S NAME (First, Middle, Last) Unavailable					18. MOTHER'S NAME (First, Middle, Maiden Surname) Ramona Zarate								
19a. INFORMANT'S NAME (Type/Print) Joan Zarate (Wife)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9373 Bremerton Way, Gaithersburg, Maryland, 20879											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) National Cemetery			DATE May 31, 1995.	20c. LOCATION — City or Town, State Culpeper, Virginia							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► W.H. Bacon										22. NAME AND ADDRESS OF FACILITY W.H. Bacon Funeral Home	20010		
										3447-14th Street, N.W. Washington, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Cardiopulmonary Failure DUE TO (OR AS A CONSEQUENCE OF): Serous T-cell Leukemia													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Hospice Care											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED Hospice Care						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D 35854								29d. DATE SIGNED (Month, Day, Year) ► 5-26-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Leszek Karowiec 501 N. Frederick Ave Gaithersburg 20877													
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE [Signature]								DNMH-10 Rev 1/90			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

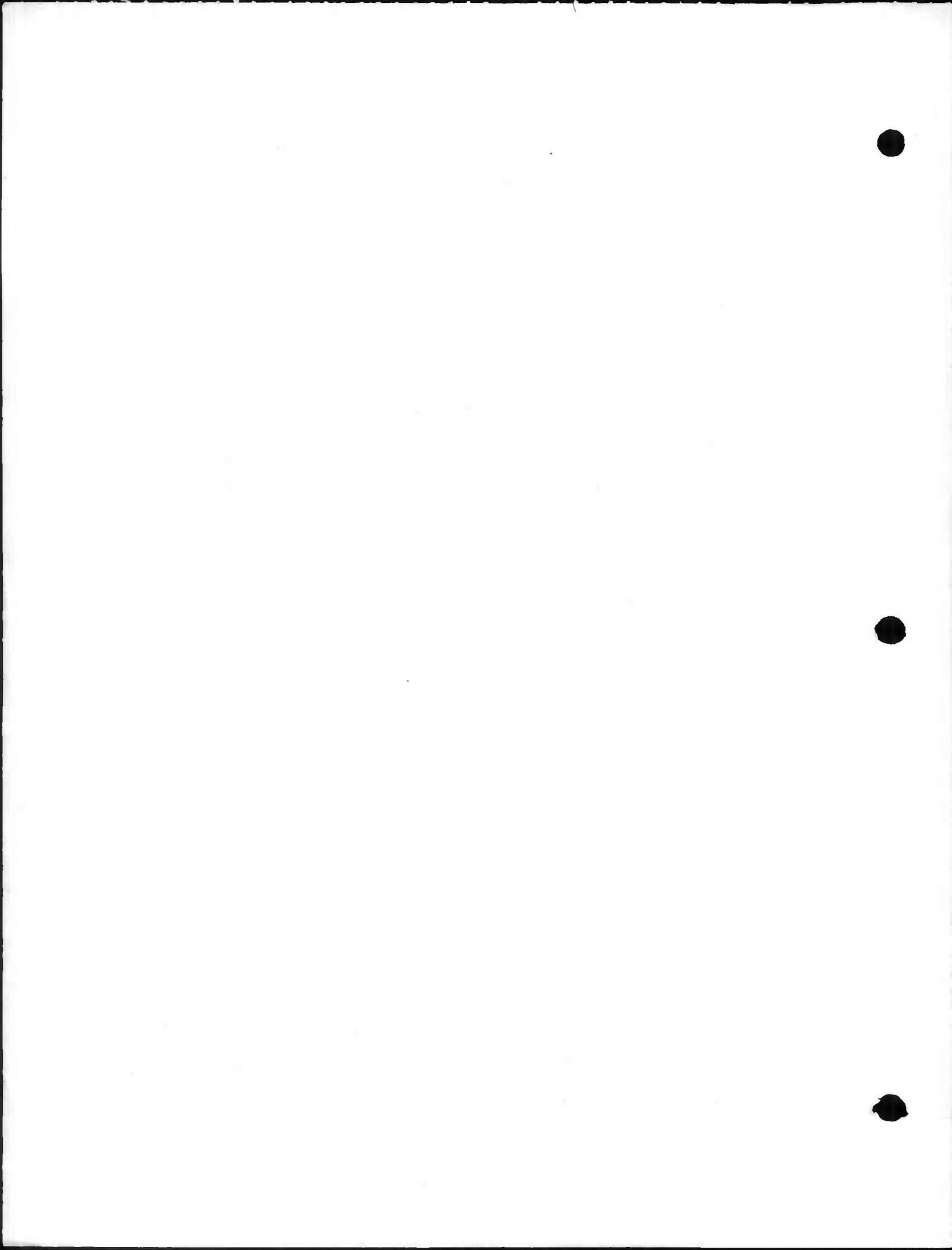
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) FRANCIS J. AHERN, Jr.								2. DATE OF DEATH MONTH June DAY 23 YEAR 1995	3. TIME OF DEATH 3:10 p.m.
4. SOCIAL SECURITY NUMBER 009-01-1696		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH Month, Day, Year May 11, 1918	8. BIRTHPLACE (State or Foreign Country) New York, New York
9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 X YES 2 NO	
10e. STREET AND NUMBER 1532 Ramblewood Road				10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Salesman				16b. KIND OF BUSINESS/INDUSTRY Furniture Industry			
17. FATHER'S NAME (First, Middle, Last) Francis James Ahern, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Brooks					
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Janes Ahern				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1532 Ramblewood Road Baltimore, Maryland 21239					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Institution, etc., and place)				DATE 6-27-95		20c. LOCATION — City or Town, State Baltimore City, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jeffrey L. Gair		22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____									
Approximate Interval Between Onset and Death Weeks									
Approximate Interval Between Onset and Death Years									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6/14/95		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED N/A			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Samuel C. Mallon		29c. LICENSE NUMBER AP2438946				29d. DATE SIGNED (Month, Day, Year) 6/23/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Samuel C. Mallon Union Memorial Hospital									
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Jean Shuler-Hardell							

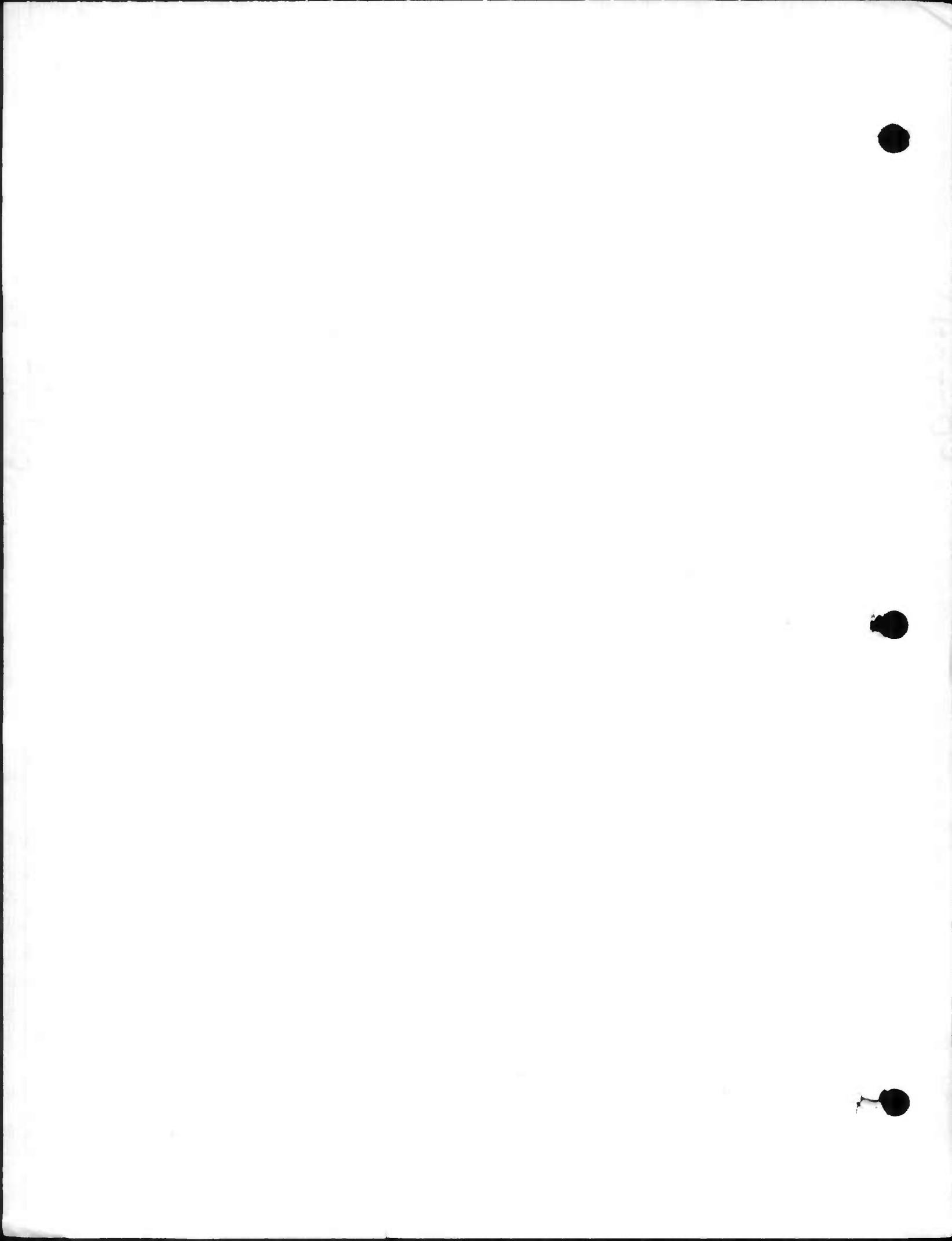


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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		Beatrice Lillian Alston				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH HRS. MIN.	
4. SOCIAL SECURITY NUMBER 215-22-1505		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
8a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center						7. DATE OF BIRTH Month, Day, Year Aug 7, 1924		8. BIRTHPLACE (State or Foreign Country) Va	
9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA							
RESIDENCE OF DECEDENT									
10a. STATE Md	10b. COUNTY NA	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 1556 Fulton Avenue		10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U.S.A			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) NA Nurse				16b. KIND OF BUSINESS/INDUSTRY Nursing Home			
17. FATHER'S NAME (First, Middle, Last) Herbert Wise		16. MOTHER'S NAME (First, Middle, Maiden Surname) Sula Wise							
18a. INFORMANT'S NAME (Type/Print) Daphne Alston		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1556 Fulton Avenue Baltimore 21217							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet 6/26/95				DATE		20c. LOCATION — City or Town, State Owings Mills, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dala March		22. NAME AND ADDRESS OF FACILITY March F. H. West 4300 Wabash Ave Baltimore 21217							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CANCER OF THE BREAST DUE TO (OR AS A CONSEQUENCE OF): b. METASTASIS TO LUNGS AND BONE DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____									
Approximate Interval Between Onset and Death									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29b. SIGNATURE AND TITLE OF CERTIFIER Anthony DASILVA		29c. LICENSE NUMBER D 32750				29d. DATE SIGNED (Month, Day, Year) JUNE 19 th 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANTHONY DASILVA 2600 LIBERTY HEIGHTS AVE, BALTO MD 21215									
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. APPROVAL John Jackson, R.N., R.N.C.							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

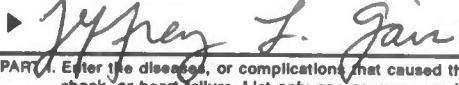
TO BE COMPLETED BY MEDICAL CERTIFICATION

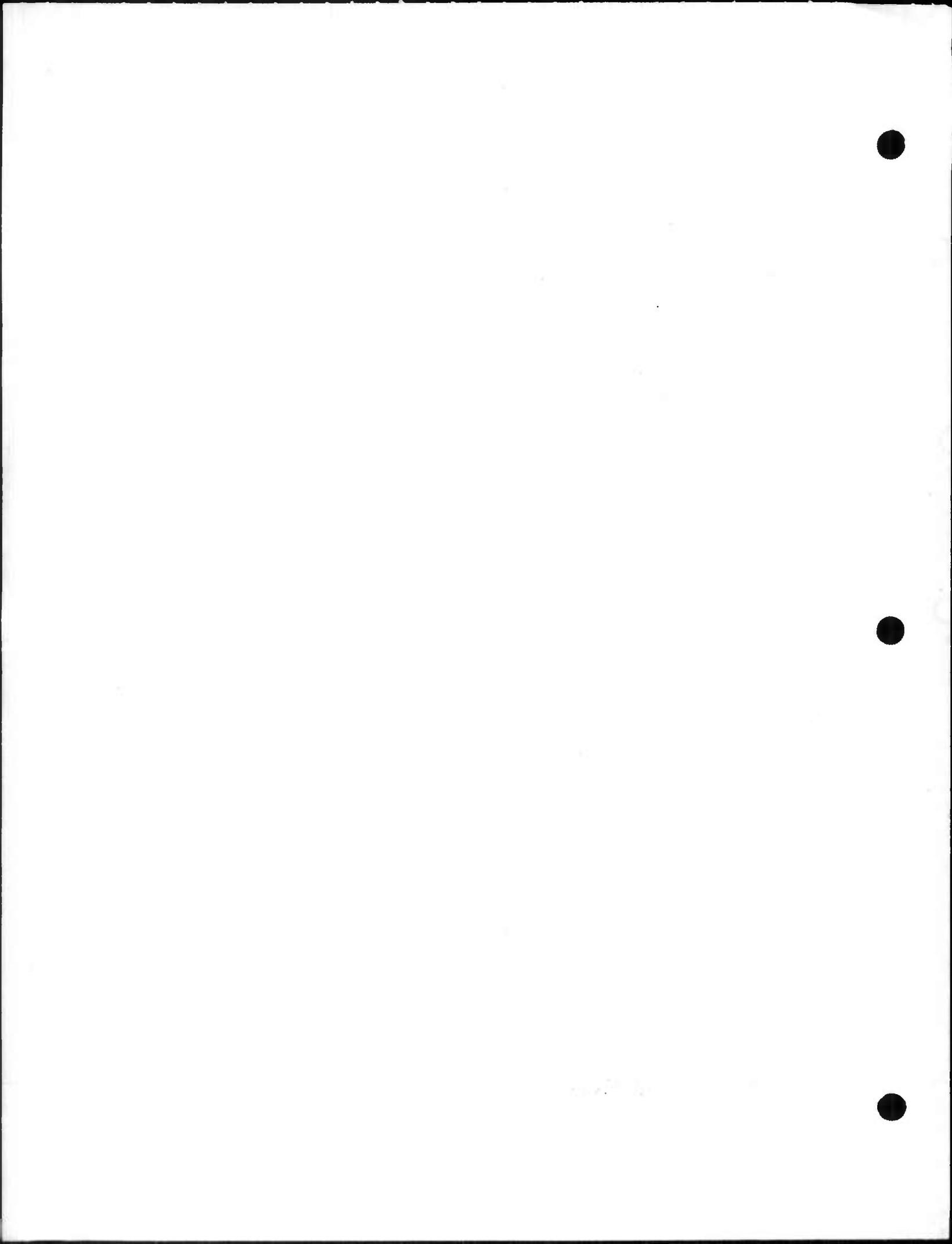
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19232

1. DECEDENT'S NAME (First, Middle, Last) Bradford Neff BLAKE						2. DATE OF DEATH MONTH June DAY 23 YEAR 1995	3. TIME OF DEATH 9:10 pm.	
4. SOCIAL SECURITY NUMBER 233-20-9243 5. SEX M 6. AGE (In yrs. last birthday) 75 YRS.						IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Dec. 15, 1919	8. BIRTHPLACE (State or Foreign Country) West Virginia
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Rossville	9c. COUNTY OF DEATH Baltimore County	
10e. STATE Maryland 10b. COUNTY N/A						10c. CITY, TOWN OR LOCATION Baltimore	10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10e. STREET AND NUMBER 5434 Hilltop Avenue						10f. ZIP CODE 21206	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE WAR OR DATES W.W. II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> Specify:		14. RACE — American Indian, Black, White, etc. White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fleet Supervisor		16b. KIND OF BUSINESS/INDUSTRY Dairy				
17. FATHER'S NAME (First, Middle, Last) Newman Blake						16. MOTHER'S NAME (First, Middle, Maiden Surname) Prudence Faulkner		
18e. INFORMANT'S NAME (Type/Print) Salena Blake						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5434 Hilltop Ave. Balto. Md. 21206		
20e. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/>			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gard. Of Faith Cem. 6-27-95			DATE	20c. LOCATION — City or Town, State Rossville Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Balto.. Md 21214		
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
<p>a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Chronic Obstructive Pulmonary Disease DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. Pneumothorax DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. Pneumonia</p>								
Approximate Interval Between Onset and Death 5 Years								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial Fibrillation						24a. WAS AN AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO <input type="checkbox"/> YES <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient ER/Outpatient <input type="checkbox"/> DOA Other: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined <input type="checkbox"/>		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	28d. DESCRIBE HOW INJURY OCCURED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER YES <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER 1051	29d. DATE SIGNED (Month, Day, Year) June 23, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Loh, MD. 617 A. Stemmers Run Road, Baltimore, Maryland 21221								
31. DATE FILED (Month, Day, Year) JUN 26 1995 								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

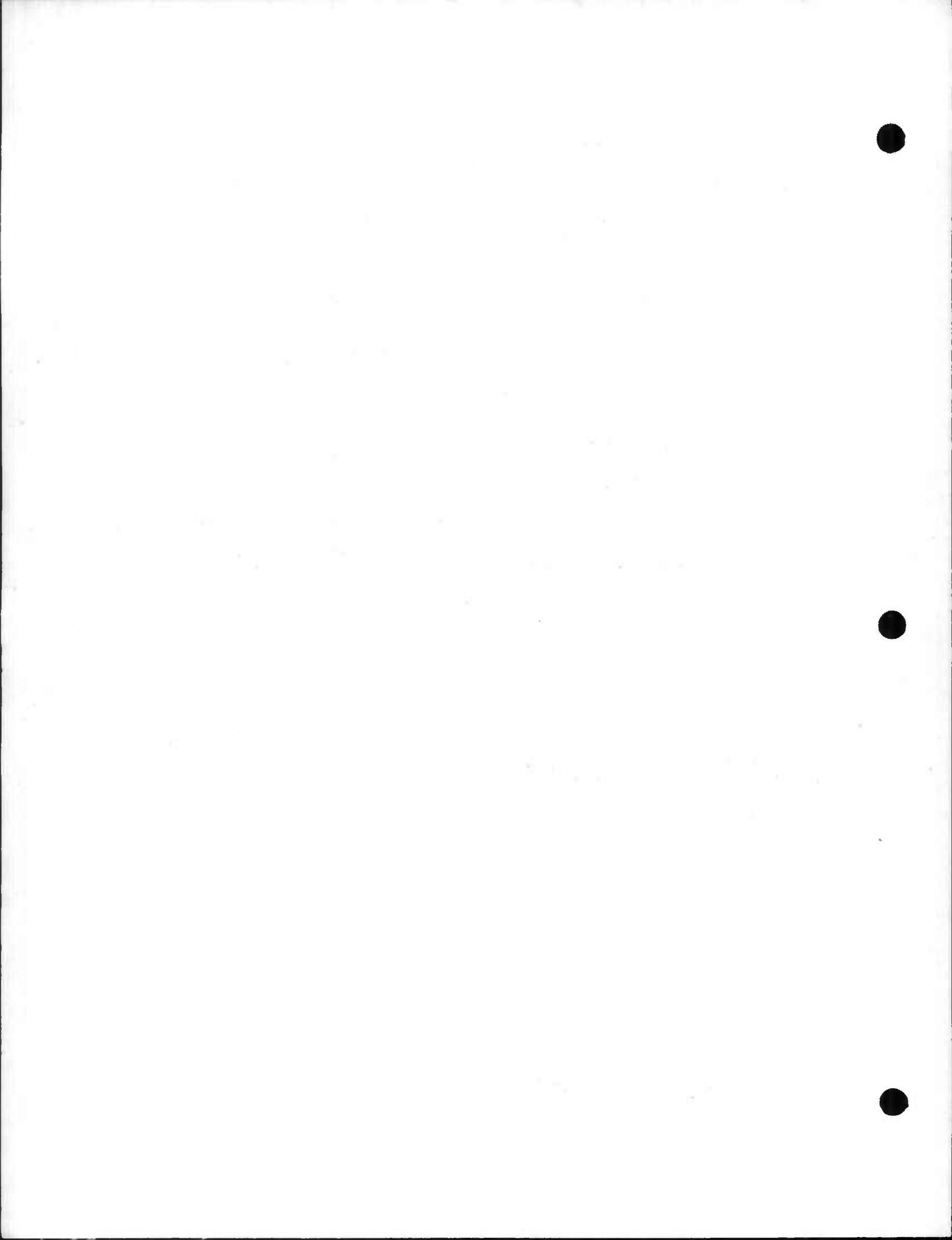
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
Edna S. Beck											June 20, 1995	1:00 AM	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. IF UNDER 1 YEAR	8. IF UNDER 24 HRS.	9. MONTH	10. DAY	11. YEAR	12. BIRTHDAY	13. BIRTHPLACE (State or Foreign Country)			
220-09-2480		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	92 YRS.	MONTHS	DAYS	HOURS	MIN.		1-2-1903	Maryland			
9a. FACILITY NAME (If not institution, give street and number)											9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH	
2012 Cypress Drive											Belair	Harford	
RESIDENCE OF DECEDENT													
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
Maryland	Harford	Belair											
10e. STREET AND NUMBER					10f. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?			
2012 Cypress Drive					21015					U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES*			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesperson			16b. KIND OF BUSINESS/INDUSTRY O'Neil's								
Elementary/Secondary (0-12) 9		College (14 or 5+)											
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)								
George Albert Gipe					Ann Elizabeth Stein								
19a. INFORMANT'S NAME (Type/Print)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Edna A. Uttenreither					Same As #10								
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE		20c. LOCATION — City or Town, State						
		Baltimore Cemetery			6-23-95		Baltimore, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Wallace S Brooks Jr					22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Road, Towson, Md. 21204								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. <i>Breast Carcinoma</i>													
Approximate Interval Between Onset and Death UNKNOWN													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
{ b. c. d.													
DUE TO (OR AS A CONSEQUENCE OF):													
PART II Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Obstructive Pulmonary Disease</i> <i>Anemia</i>													
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)			OTHER: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fredric S. Siekis M.D.</i>										29c. LICENSE NUMBER D22645	29d. DATE SIGNED (Month, Day, Year) ► 6/20/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year) JUN 26 1995										32. REGISTRAR'S SIGNATURE <i>Jane Shuler Harrell</i>	



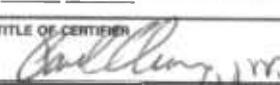
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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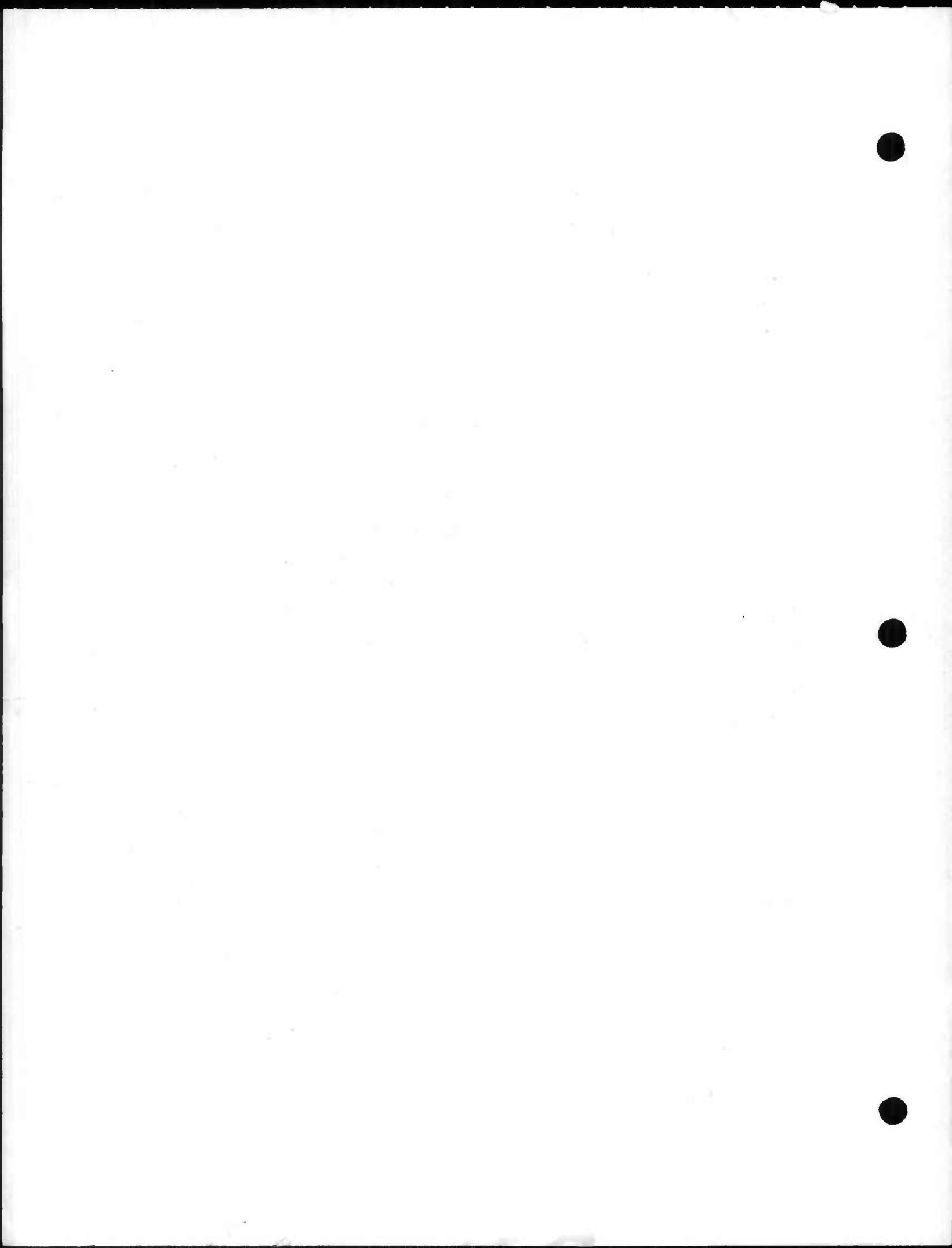
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
Frances Lee Bradford										June 22, 1995	11:00 a.m.		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
234 66 5931		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	52 YRS.	MONTHS	DAYS	HOURS	MIN.			Oct. 8, 1942		West Virginia	
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
343 Trimble Road Apt. "B1"										Joppa		Harford	
RESIDENCE OF DECEASED													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?			
Maryland		Harford		Joppa						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER										10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
343 Trimble Road Apt. "B1"										21085		U.S.A.	
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced													
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+)				Computer Operator				U.S. Government			
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)			
Unknown										Leta McLaughlin			
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Leta Wilt										396 E. Wolf Street Harrisonburg, Virginia 22801			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
		Holly Hill Mem. Gardens 6/24/95						Baltimore Co., Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Eastern Ave Baltimore, Maryland 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. <u>Metastatic colon cancer</u>										<u>~3 years</u>			
b. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):													
c. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):													
d. <u> </u> DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)											
1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								OTHER:			
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
29e. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29g. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER D16587		29d. DATE SIGNED (Month, Day, Year) ► 6/24/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
Paul Chang, MD 5601 Rock River Blvd, Balto, MD 21239													
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE 											
JUN 26 1995													

95 19234



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 29 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

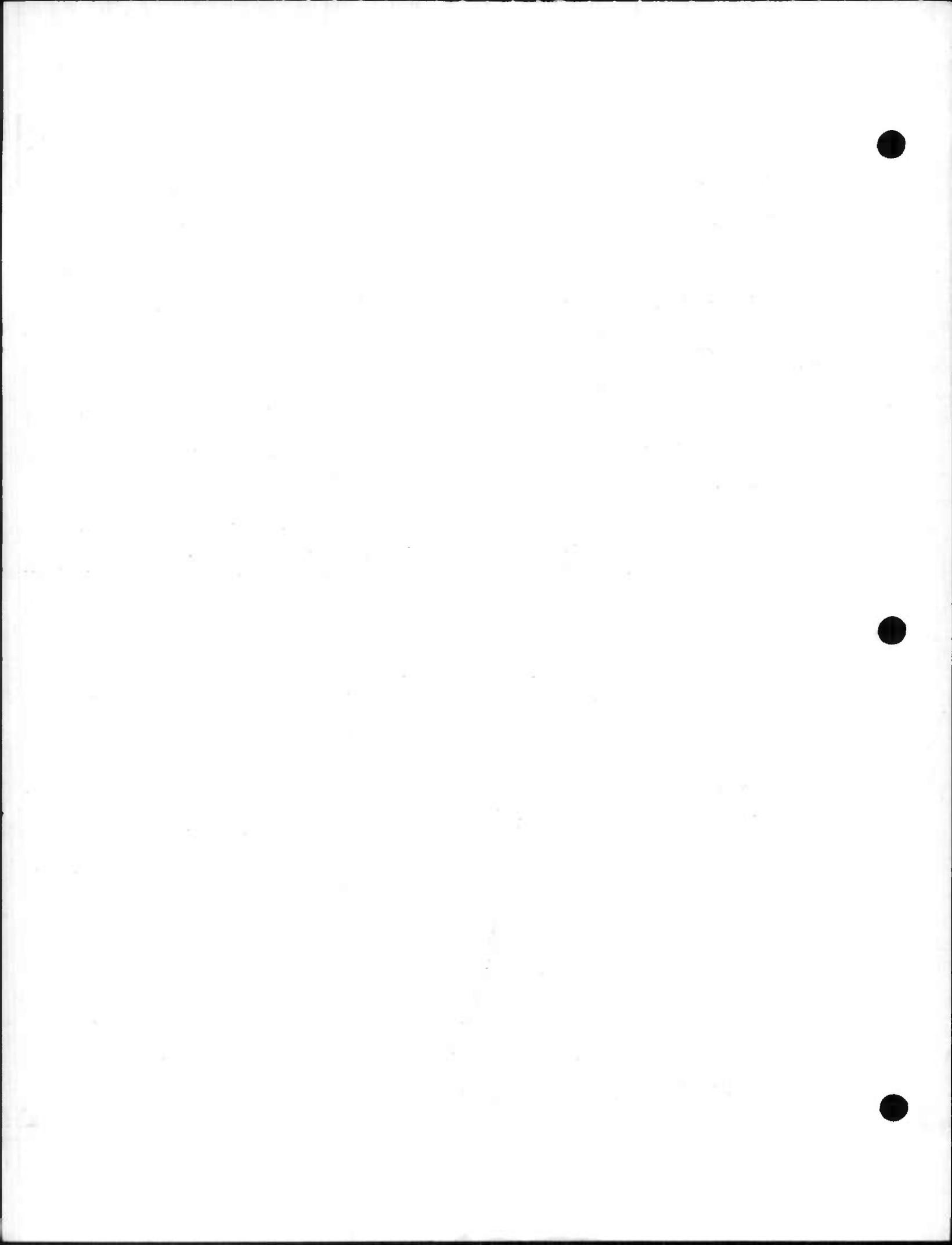
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19235

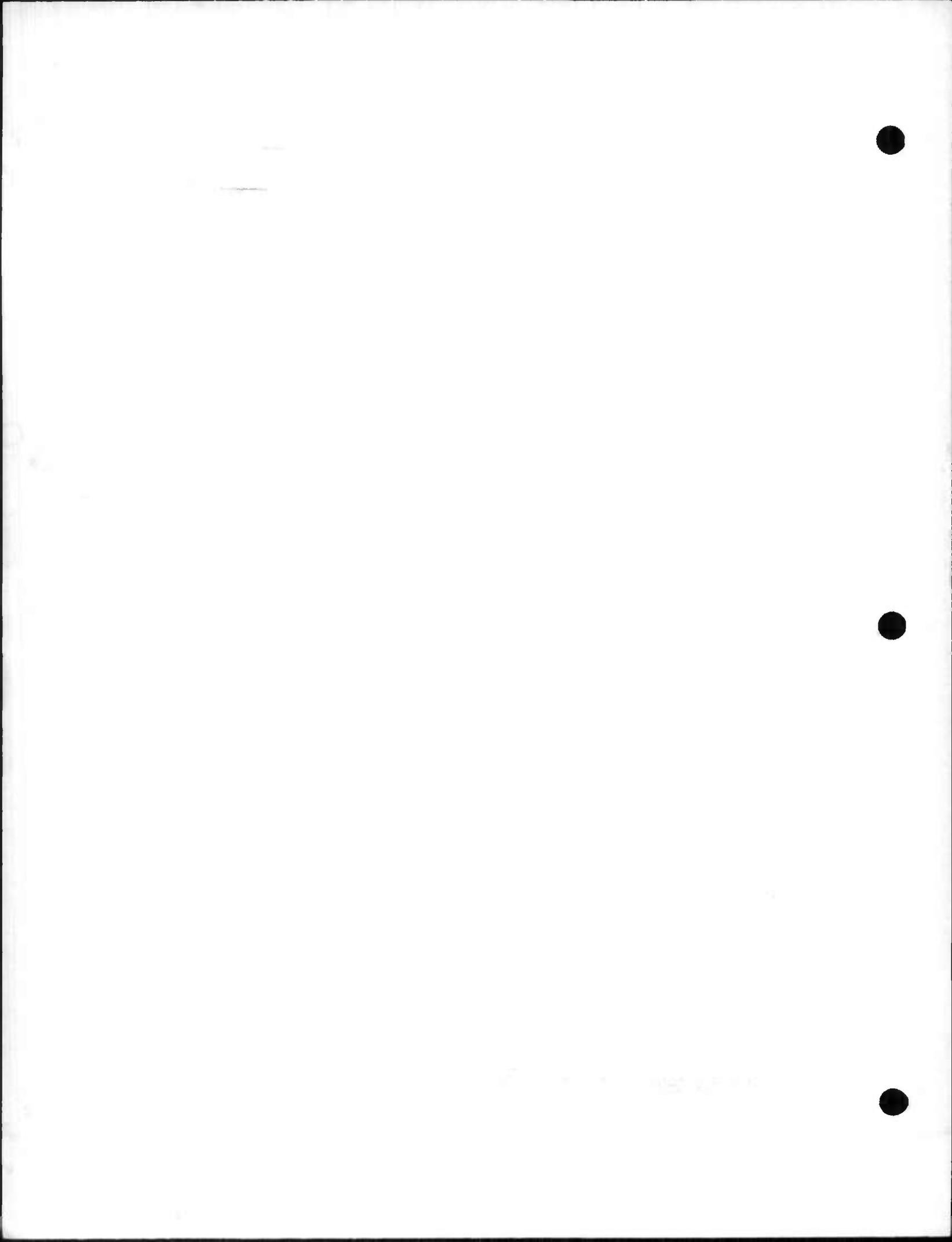
1. DECEASED'S NAME (First, Middle, Last) MARTHA R. BUCKMAN						2. DATE OF DEATH MONTH JUNE DAY 22, 1995 YEAR	3. TIME OF DEATH 5:30 P M				
4. SOCIAL SECURITY NUMBER 219-30-8575		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APR. 5, 1931	8. BIRTHPLACE (State or Foreign Country) MARYLAND				
9a. FACILITY NAME (If not institution, give street and number) 8202 KRAMER CT., APT. 2D				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE		9c. COUNTY OF DEATH ANNEARUNDEL					
RESIDENCE OF DECEASED											
10a. STATE MARYLAND	10b. COUNTY ANNE ARUNDEL	10c. CITY, TOWNS OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 8202 KRAMER CT., APT. 2D				10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) QUALITY ENGINEER			16b. KIND OF BUSINESS/INDUSTRY PLASTIC MANUFACTURING						
17. FATHER'S NAME (First, Middle, Last) JOHN STANLEY ZELNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) FANNIE MAE EISENHOWER							
19a. INFORMANT'S NAME (Type/Print) SHARON GOLDSTEIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 977, BROOKLANDVILLE, MD 21022							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) GLEN HAVEN MEM. PK.			JUNE 26, 1995	20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Sudden Cardiac Death</i> Approximate Interval Between Onset and Death DUE TO (OR AS A CONSEQUENCE OF): <i>Immediate 1980</i></p> <p>b. <i>Hypertension</i></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Elevated cholesterol 1992 Right Mastectomy Sept - 1994</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) M	28b. TIME OF INJURY 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard E. Fisher M.D.</i>						29c. LICENSE NUMBER DO 2619		29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD E. FISHER, 1600 CRAIN HWY., S., SUITE 208, GLEN BURNIE, MARYLAND 21061						31. DATE FILED JUN 26 1995					
32. REGISTRAR'S SIGNATURE <i>John Andrew Marshall</i>						DHMH-18 Rev 1/89					



FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH		3. TIME OF DEATH	
MARY Jane BECKER		June 24 95		12:55PM	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.
220-05-3016		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	80 YRS.	MONTHS	DAYS
7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)		9. COUNTY OF DEATH	
Sept. 19, 1924 - 1914		Baltimore, Md.		N/A	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
Good Samaritan Hospital		Baltimore City		N/A	
RESIDENCE OF DECEASED					
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?	
Maryland	N/A	Baltimore City		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
3806 Echodale Ave.		21206		U.S.A.	
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12) 08		College (1-4 or 5+) Envelope Machine Operator		Stationary	
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)			
John Joseph Becker		Mary Josephine Burke			
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Mrs. Mary P. Higgins		3806 Echodale Ave. Baltimore, Maryland 21206			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, organization, or other place) New Cathedral Cem.		DATE 6-28-95	20c. LOCATION — City or Town, State Baltimore City, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Jeffrey L. Gair		22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
a. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):					
b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):					
Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Janet Talusan, M.D.			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		29c. LICENSE NUMBER 044001		29d. DATE SIGNED (Month, Day, Year) ► 6/24/95	
31. DATE FILLED (Month, Day, Year) JUN 26 1995		31. REGISTRATION SIGNATURE John William Kelleher			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

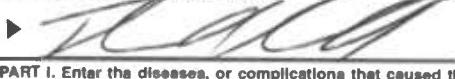
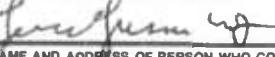
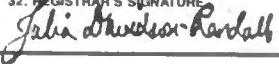
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

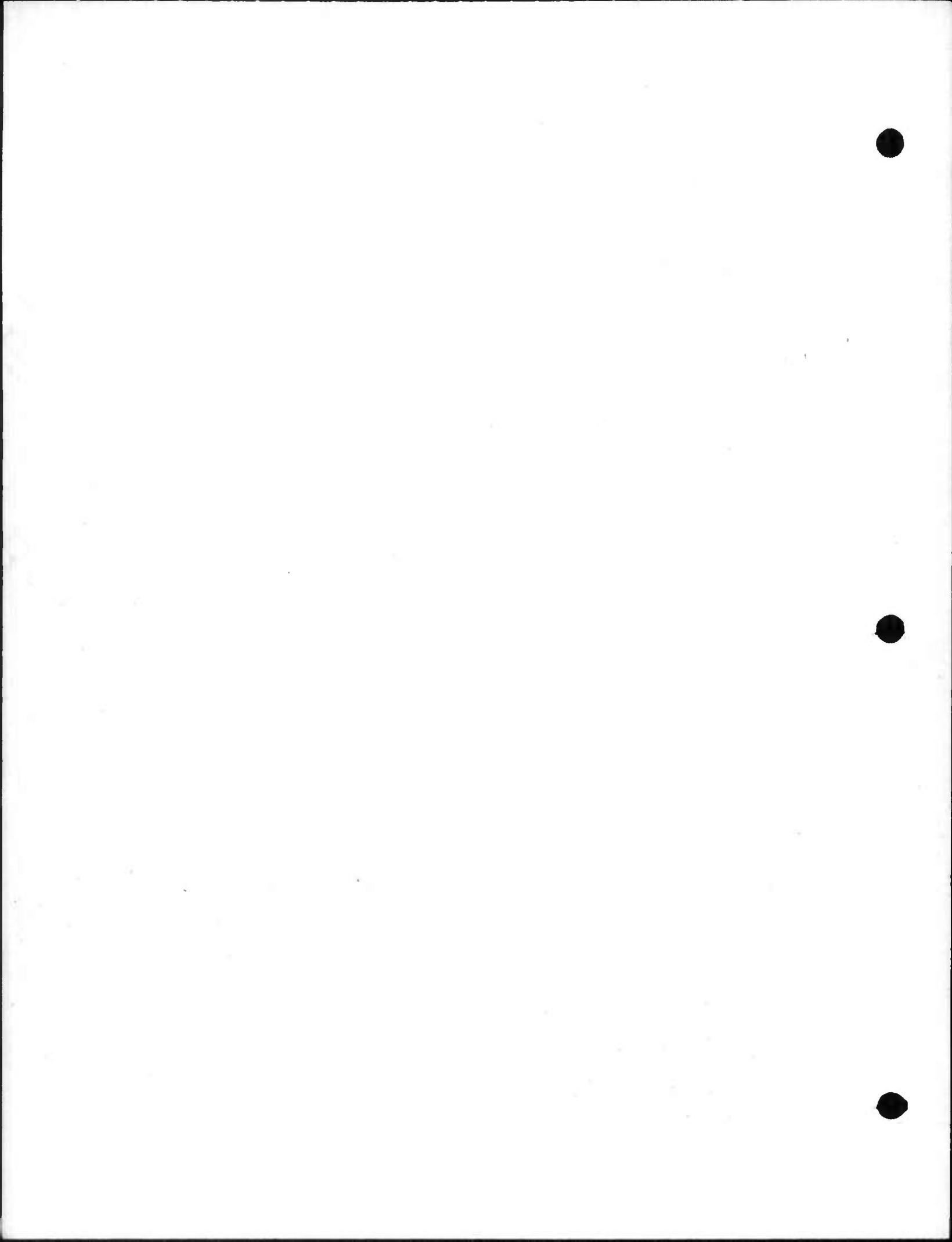
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR		FilmG, 724, item #1, 6/26/95, cyw, per f.h. STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						95 19237	
								REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		JULIA WILLIAMS BROWNE				2. DATE OF DEATH MONTH 6 DAY 17 YEAR 95		3. TIME OF DEATH 1535 M	
<i>Brown</i>		<i>JULIA W.</i>							
4. SOCIAL SECURITY NUMBER 215-34-7236		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 27, 1906	
								8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore						9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT									
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 700 W. 40th St.		10f. ZIP CODE 21211						10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Housewife				16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) William Smith Gittings Williams		18. MOTHER'S NAME (First, Middle, Maiden Surname) Julia Bell Deford							
19a. INFORMANT'S NAME (Type/Print) C. Willing Browne, III		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 32 Wedge Way Littleton, CO 81123							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park				DATE 6-21		20c. LOCATION — City or Town, State Baltimore, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
<p>a. <i>Massive upper gi bleeding, acute</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>? Peptic ulcer with esophageal tear?</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i></p>									
Approximate Interval Between Onset and Death 2 hours									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {									
. Immediate									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>SP abdominal pain resulting from colitis</i> <i>ASCVD</i> <i>Dehydration</i>									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or town, State)	
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 001782				29d. DATE SIGNED (Month, Day, Year) ► 6/17/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Lee Gresser M.D. 7801 York Rd. Towson, Md. 21204									
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 							



95 19238

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

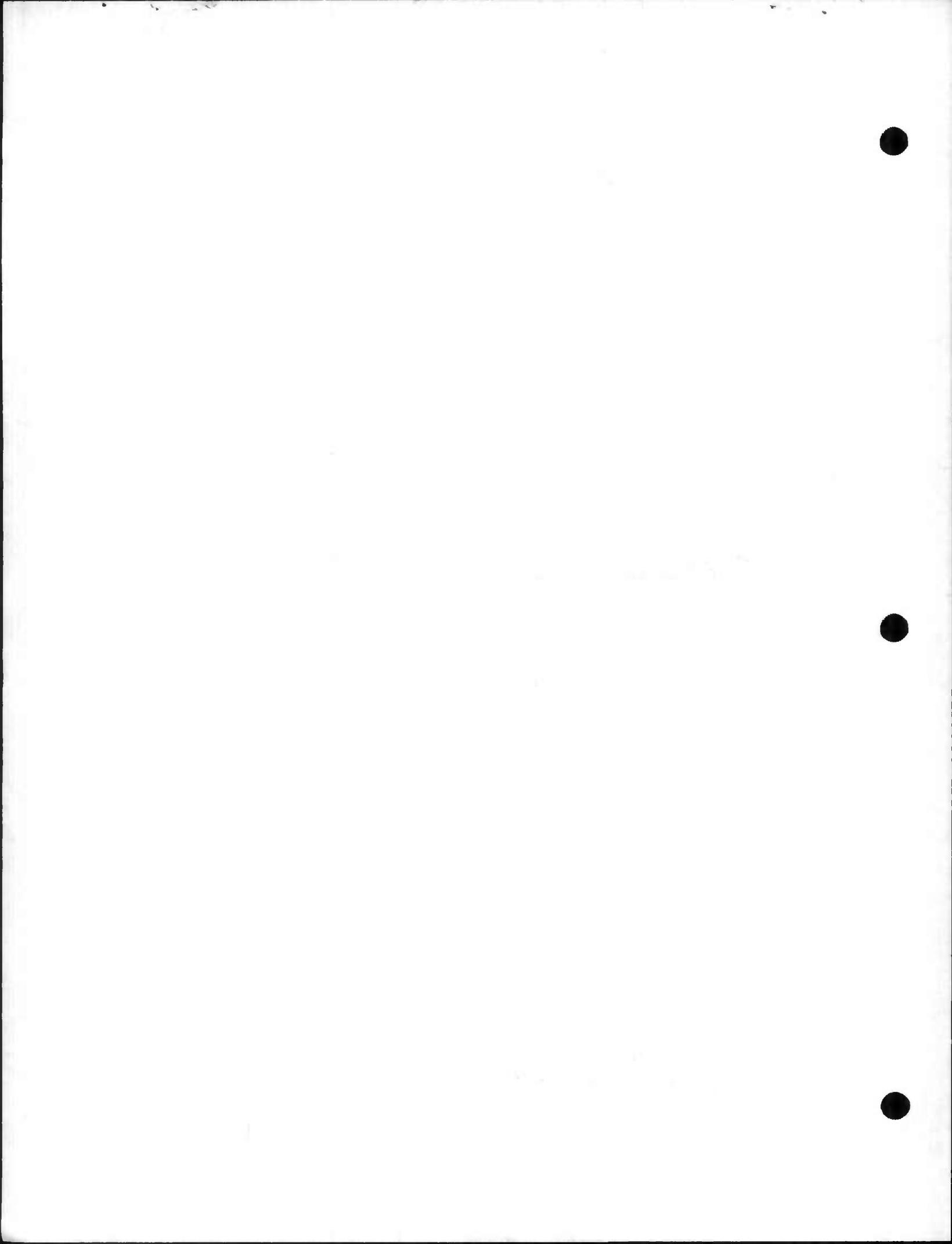
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH <u>06</u> DAY <u>25</u> YEAR <u>95</u>	3. TIME OF DEATH <u>2345</u>
<u>JAMES T BAKER</u>											
4. SOCIAL SECURITY NUMBER <u>301-34-8839</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>55</u> YRS.		IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>		7. DATE OF BIRTH (Month, Day, Year) <u>04/ 26/1940</u>	
8a. FACILITY NAME (If not Institution, give street and number) <u>University Of Maryland Med. System</u>										8b. BIRTHPLACE (State or Foreign Country) <u>Ohio</u>	
9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>										9c. COUNTY OF DEATH <u>N/A</u>	
10a. STATE <u>MD.</u>		10b. COUNTY <u>N/A</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>790 W. Cross Street</u>						10f. ZIP CODE <u>21230</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>1958-1961</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12)</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Grocer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Food Sales</u>							
17. FATHER'S NAME (First, Middle, Last) <u>James Edwin Baker</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Alma (Unknown)</u>							
19a. INFORMANT'S NAME (Type/Print) <u>Eleanor Baker</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>790 W. Cross St. Baltimore, Md. 21230</u>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>McPherson Cemetery</u>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>McPherson Cemetery</u>		DATE <u>6-30</u>		20c. LOCATION — City or Town, State <u>Clyde Ohio</u>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kathleen Weber</u>		22. NAME AND ADDRESS OF FACILITY <u>David J. Weber Funeral Home 401 S. Chester St. Balto. Md. 21231</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>coronary artery disease</u> DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____											
DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u></u>		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>W. M.D.</u>		29c. LICENSE NUMBER <u>045857</u>		29d. DATE SIGNED (Month, Day, Year) <u>6/26/95</u>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>DICK KUD, UNIVERSITY OF MARYLAND MEDICAL SYSTEM</u>											
31. DATE FILED (Month, Day, Year) <u>JUN 26 1995</u>		32. REGISTRAR'S SIGNATURE <u>John W. Weber</u>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

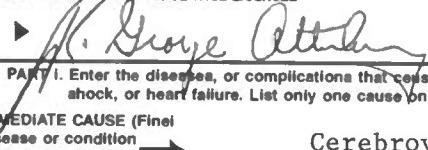
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

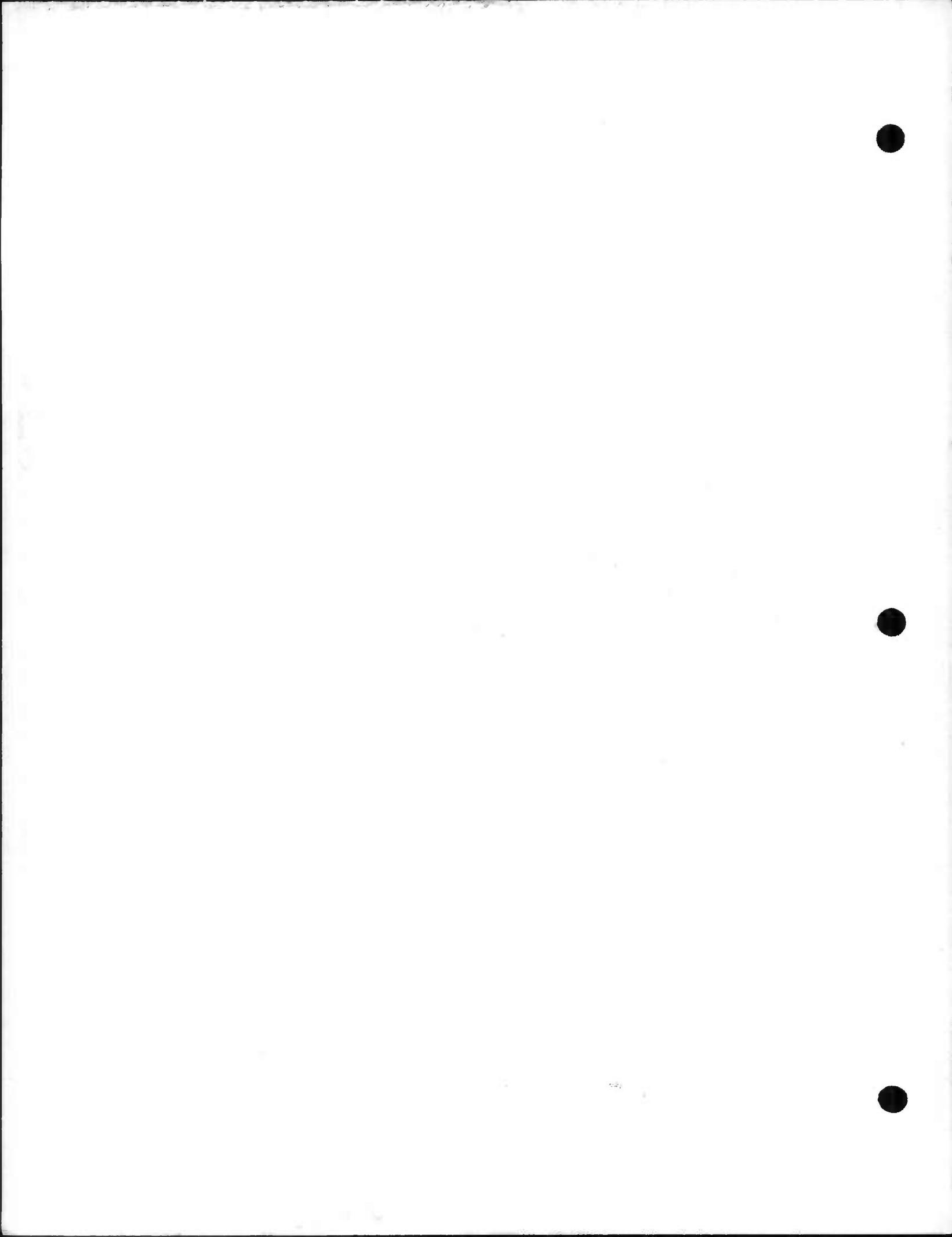
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Robert Enders BURK										2. DATE OF DEATH MONTH DAY YEAR June 24, 1995	3. TIME OF DEATH p.m. 3:45		
4. SOCIAL SECURITY NUMBER 219-16-7567		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 24, 1922		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital Center										9b. CITY, TOWN OR LOCATION OF DEATH Rossville	9c. COUNTY OF DEATH Baltimore County		
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION White Marsh				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 5418 Forge Rd.				10f. ZIP CODE 21162				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES ✓			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Truck Driver			16b. KIND OF BUSINESS/INDUSTRY Stebbins Anderson								
17. FATHER'S NAME (First, Middle, Last) Frederick Burk					18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Enders								
19a. INFORMANT'S NAME (Type/Print) Nancy G. Burk					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5418 Forge Rd., White Marsh, MD 21162								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Prospect Hill Cemetery				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Prospect Hill Cemetery			DATE 6/28	20c. LOCATION — City or Town, State Towson, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A. 6009 Harford Rd., Baltimore, MD 21214								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident										Approximate Interval Between Onset and Death 4 days			
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {													
b. DUE TO (OR AS A CONSEQUENCE OF): {													
c. DUE TO (OR AS A CONSEQUENCE OF): {													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient 1 <input checked="" type="checkbox"/> ER/Outpatient 2 <input type="checkbox"/> DOA 3 <input type="checkbox"/> OTHER: Nursing Home 4 <input type="checkbox"/> Residencia 5 <input type="checkbox"/> Other (Specify) 6 <input type="checkbox"/>											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residencia 6 <input type="checkbox"/> Other (Specify)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) At home						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) City or Town, State	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Bashar Karakash M.D.										29c. LICENSE NUMBER RD 1648	29d. DATE SIGNED (Month, Day, Year) ► 6/24/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Bashar Karakash, M.D., 9000 Franklin Square Drive, Baltimore, Maryland 21237													
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Julie Anderson-Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

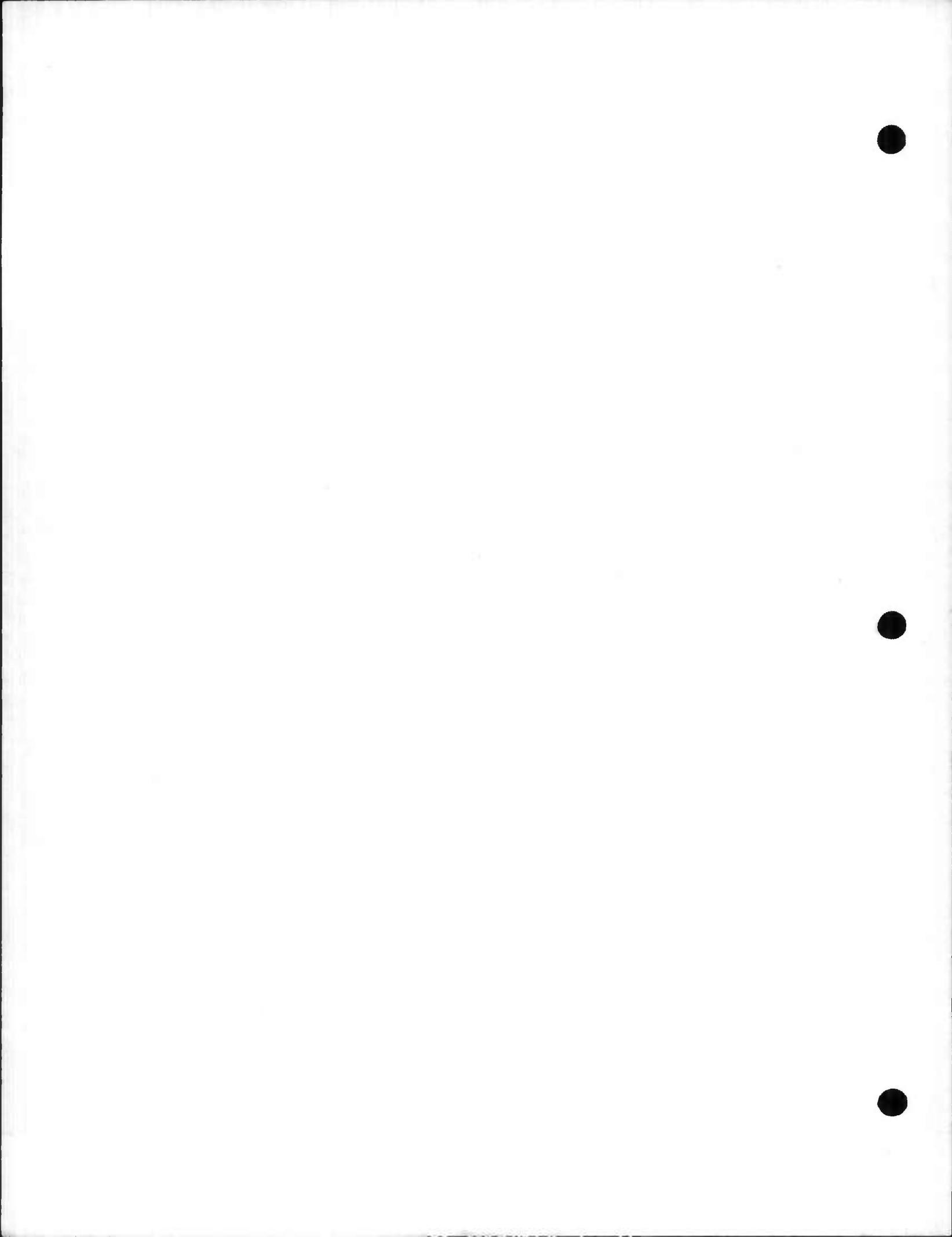
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <i>Colleen Brown</i>						2. DATE OF DEATH MONTH 6 DAY 4 YEAR 95		3. TIME OF DEATH P.M.	
4. SOCIAL SECURITY NUMBER 412-07-1413		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) OCT. 30, 1911	8. BIRTHPLACE (State or Foreign Country) GEORGIA
9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE						9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4017 LIBERTY HEIGHTS AVENUE		10f. ZIP CODE 21207						10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEKEEPER			16b. KIND OF BUSINESS/INDUSTRY PRIVATE HOMES				
17. FATHER'S NAME (First, Middle, Last) ARTHUR		18. MOTHER'S NAME (First, Middle, Maiden Surname) HARRIS MARY							
19a. INFORMANT'S NAME (Type/Print) JESSIE HUNTER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 710 JESSE JEWELL PARKWAY S.E., GAINESVILLE, GA, 30501							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MT. ZION CEMETERY		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6-22-95			DATE 6-22-95		20c. LOCATION — City or Town, State BALTIMORE, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE D. Brown		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____}									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide							28a. DATE OF INJURY (Month, Day, Year) M	28b. TIME OF INJURY 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29d. DATE SIGNED (Month, Day, Year) 6/4/95		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>DR Edna R Hill (LMC)</i>							29c. LICENSE NUMBER 091699		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR Edna R Hill (LMC) 2600 Liberty Heights, Baltimore, MD 21215							31. DATE FILED (Month, Day, Year) JUN 26 1995		
32. REGISTRAR'S SIGNATURE <i>Audrey Marshall</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR

95-3572-510

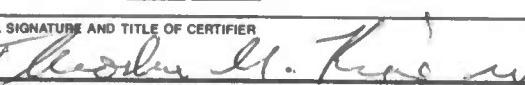
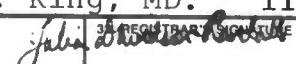
b1h

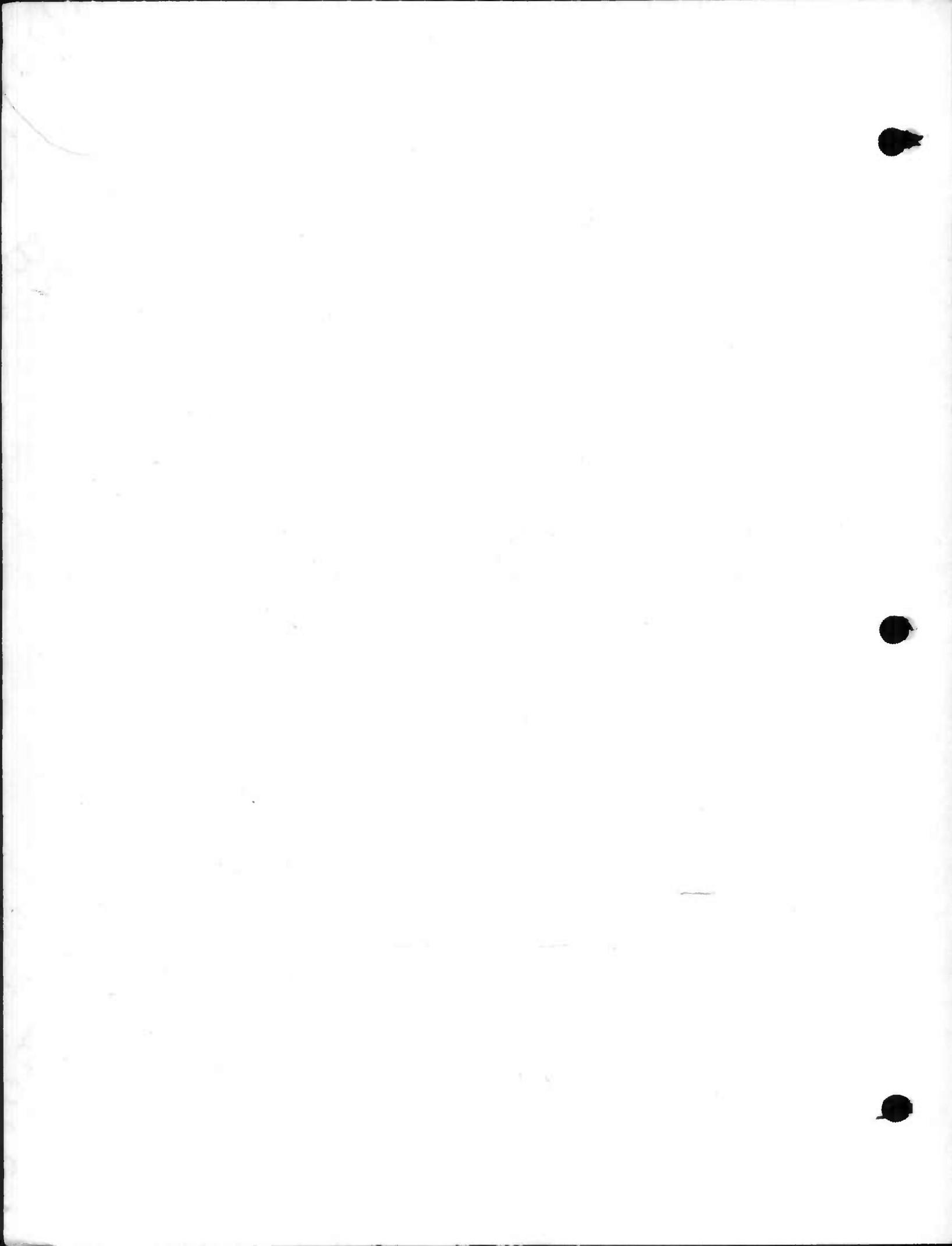
ITEMS: 23 PART II, PER MEO FILM G-726 8/10/95 t.t
ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t

95 19241

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		Bass, Jr.				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH			
Raymond						June 19 1995		0555 M			
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs, last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year)			
213-62-8191		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	33					DEC. 13, 1961			
8a. FACILITY NAME (If not Institution, give street and number) in auto-in parking lot 900 S. Caton Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEASED											
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
MARYLAND	N/A										
10e. STREET AND NUMBER 3711 FLOWERTON ROAD		10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA.					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th GRADE		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TRACTOR TRAILER DRIVER				16b. KIND OF BUSINESS/INDUSTRY MIDWAY & WEST TRUCKING CO.					
17. FATHER'S NAME (First, Middle, Last) RAYMOND BASS SR.		18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH SMITH									
19a. INFORMANT'S NAME (Type/Print) SARAH BASS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3711 FLOWERTON ROAD, BALTIMORE, MARYLAND 21229									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS CEMETERY				DATE	20c. LOCATION — City or Town, State 6-24-95 ARBUTUS, MARYLAND				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223									
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → COCAINE & NARCOTIC INTOXICATION											
b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BRONCHOPNEUMONIA											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) at scene				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND: 6-19-95		28b. TIME OF INJURY FOUND: 5:30 A M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: PARKING LOT 900 S. CATON AVENUE				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) ST. AGNES HOSPITAL 900 CATON AVE. BALTIMORE, MARYLAND					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) ► June 19 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Theodore M. King, MD.		111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. RECORDED BY SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

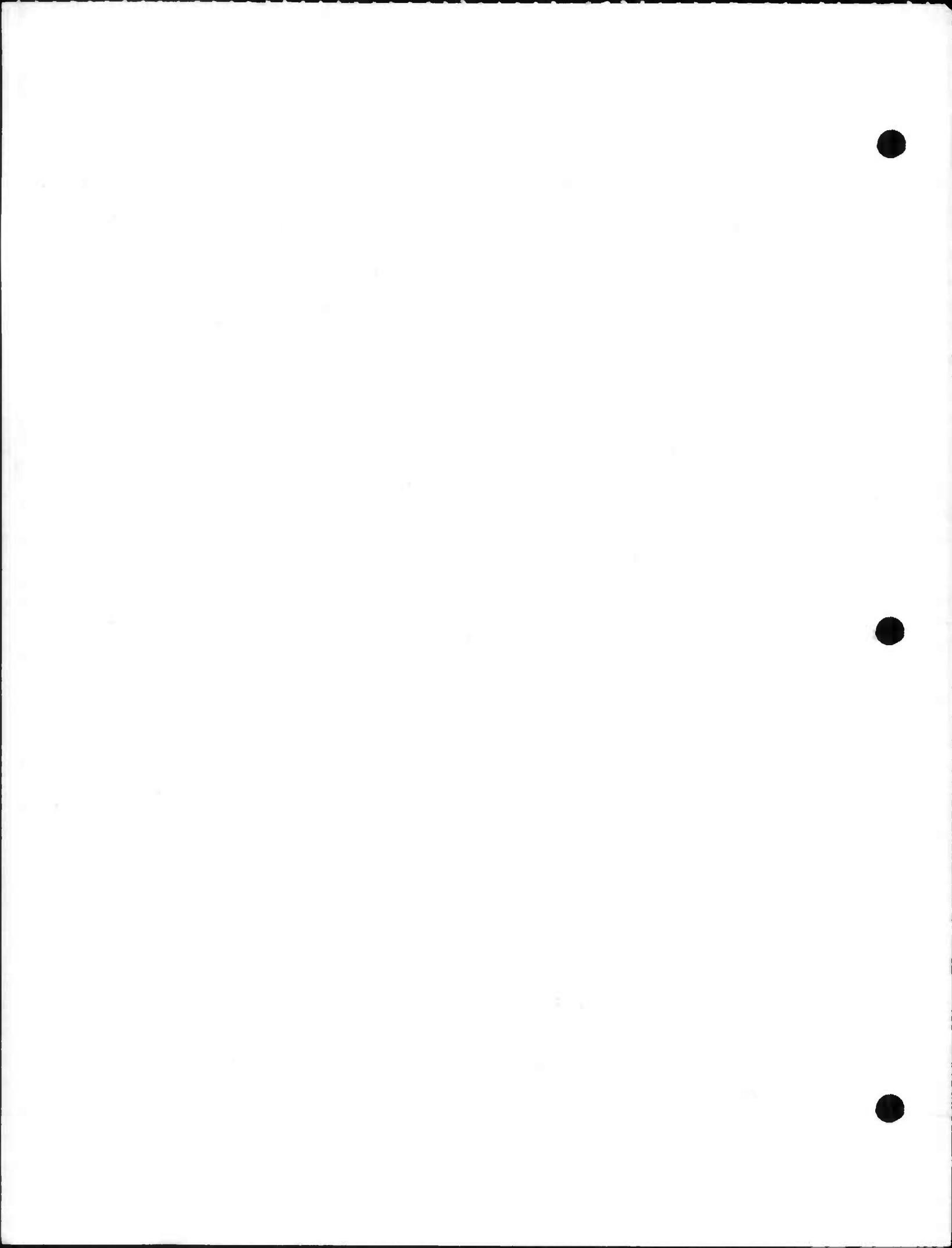
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		N. Emma Calabro								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 12:00 Noon		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)		
217-12-8163		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	94 YRS.	MONTHS	DAYS	HOURS	MIN.			Jan. 04, 1901	Pittsburgh, Pa.		
9a. FACILITY NAME (If not institution, give street and number)		Union Memorial Hospital Baltimore City								9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEASED													
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
Maryland	N/A	Baltimore City								10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
6502 Cedonia Ave.				21206									
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY									
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Contometer		Auto Leasing									
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)									
Michael Nozzolillo				Theresa Unknown									
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		20a. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
Mrs. Mabel E. Lamond		6502 Cedonia Ave. Baltimore, Maryland 21206		St. Peters Cemetery		Pittsburgh, Pa.		DATE 6-28-1995					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State									
Jeffrey L. Gair		22. NAME AND ADDRESS OF FACILITY		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21212		Approximate Interval Between Onset and Death									
e. Cardiopulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF):		5 min.											
b. Sepsis / Pyemone		4 Days											
c. URI DUE TO (OR AS A CONSEQUENCE OF):		10 days											
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?					
						1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
8 <input type="checkbox"/> Could not be determined		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER INTERN MEDICINE		29c. LICENSE NUMBER AT 2438946		29d. DATE SIGNED (Month, Day, Year) ► June 24th 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIA KARAGEORGOU, DEPT. MED. U. MH. BALTIMORE													
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE											



RKD

95-3460-025

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/30/95 t.t

95 19243

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

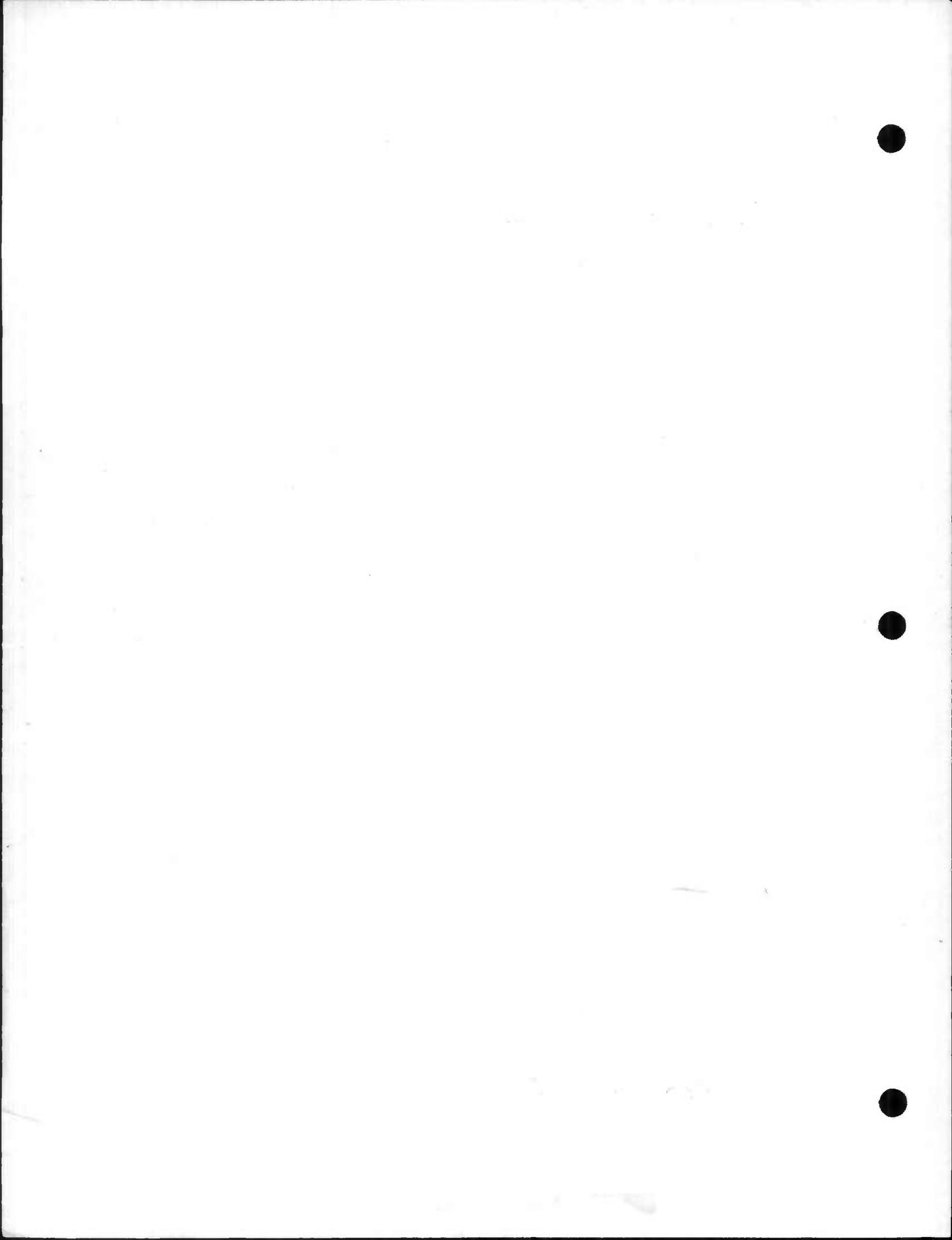
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		CRUMBLE		2. DATE OF DEATH MONTH JUNE DAY 11 YEAR 95	3. TIME OF DEATH 8:50 AM
MARCEL				7. DATE OF BIRTH (Month, Day, Year) June 1, 1995	
4. SOCIAL SECURITY NUMBER NA		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. 10	IF UNDER 1 YEAR MONTHS 10	IF UNDER 24 HRS. HOURS 10 MINN. 00
9a. FACILITY NAME (If not institution, give street and number) FALLSTON GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH FALLSTON		9c. COUNTY OF DEATH HARFORD COUNTY	
10a. STATE Md		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Edgewood	
10e. STREET AND NUMBER 1835 Grempler Way		10f. ZIP CODE 21040		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) NA		16b. KIND OF BUSINESS/INDUSTRY NA	
17. FATHER'S NAME (First, Middle, Last) Kenneth Crumble		18. MOTHER'S NAME (First, Middle, Maiden Surname) Estella Polston		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1835 Grempler Way Edgewood, Md 21040	
19e. INFORMANT'S NAME (Type/Print) Estella Polston		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hong Green Church Pen		20c. LOCATION — City or Town, State Hong Green, Md	
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		DATE March 1, 1995		Approximate Interval Between Onset and Death	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Portia Ebron		22. NAME AND ADDRESS OF FACILITY Mayhew F. H. West 1300 Wabash Ave Baltimore 21215			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
a. SUDDEN INFANT DEATH SYNDROME DUE TO (OR AS A CONSEQUENCE OF):					
b. DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 3 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED	
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29g. SIGNATURE AND TITLE OF CERTIFIER J. Laron Locke MD		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) ► JUNE 13, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Laron Locke, MD 111 Penn Street, Baltimore, Maryland 21201		31. DATE FILED (Month, Day, Year) JUN 26 1995			
32. REGISTRAR'S SIGNATURE Julie Shadwell Rarbale					

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

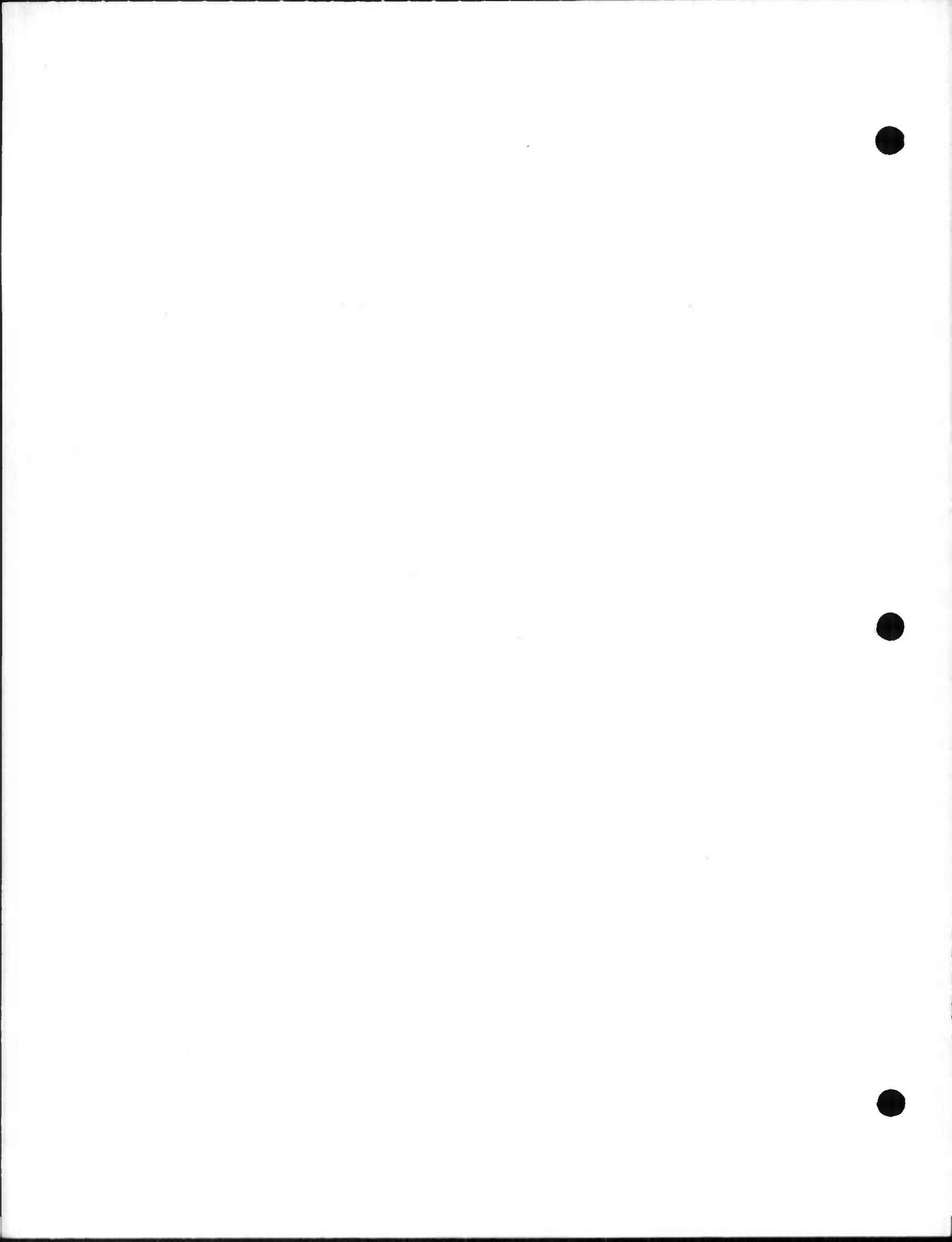
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19244

1. DECEASED'S NAME (First, Middle, Last) Margie Elizabeth Coleman						2. DATE OF DEATH MONTH DAY YEAR June 20, 1995	3. TIME OF DEATH 11:15 A M
4. SOCIAL SECURITY NUMBER 248-50-8889			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) JUL 10, 1932	8. BIRTHPLACE (State or Foreign Country) S. Carolina
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home						9b. CITY, TOWN OR LOCATION OF DEATH Dundalk	9c. COUNTY OF DEATH N/A
RESIDENCE OF DECEASED							
10a. STATE MD	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7232 German Hill Road				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)		16b. KIND OF BUSINESS/INDUSTRY Food Service Worker Bank			
17. FATHER'S NAME (First, Middle, Last) Booker Nichols				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Simmons			
19a. INFORMANT'S NAME (Type/Print) Abdul Waajid				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1334 Gittings Avenue/Baltimore, MD 21239			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery		DATE 6/22	20c. LOCATION — City or Town, State Anne Arundel Co., MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CARDIOPULMONARY ARREST							
Approximate Interval Between Onset and Death 6/26/95							
b. METASTATIC CANCER OF PANCREAS							
DUE TO (OR AS A CONSEQUENCE OF): 6/2/95							
c. QUESTION							
DUE TO (OR AS A CONSEQUENCE OF): QUESTION							
d. QUESTION							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) QUESTION	28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? QUESTION	28d. DESCRIBE HOW INJURY OCCURRED QUESTION
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) QUESTION				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) QUESTION			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER QUESTION			
29b. SIGNATURE AND TITLE OF CERTIFIER QUESTION M-A-				29d. DATE SIGNED (Month, Day, Year) ► 6/26/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAVINGER JR JAMES L. - Pleasant Place Dundalk MD 21222							
31. DATE FILED (Month, Day, Year) JUN 26 1995				32. REGISTRAR'S SIGNATURE QUESTION			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

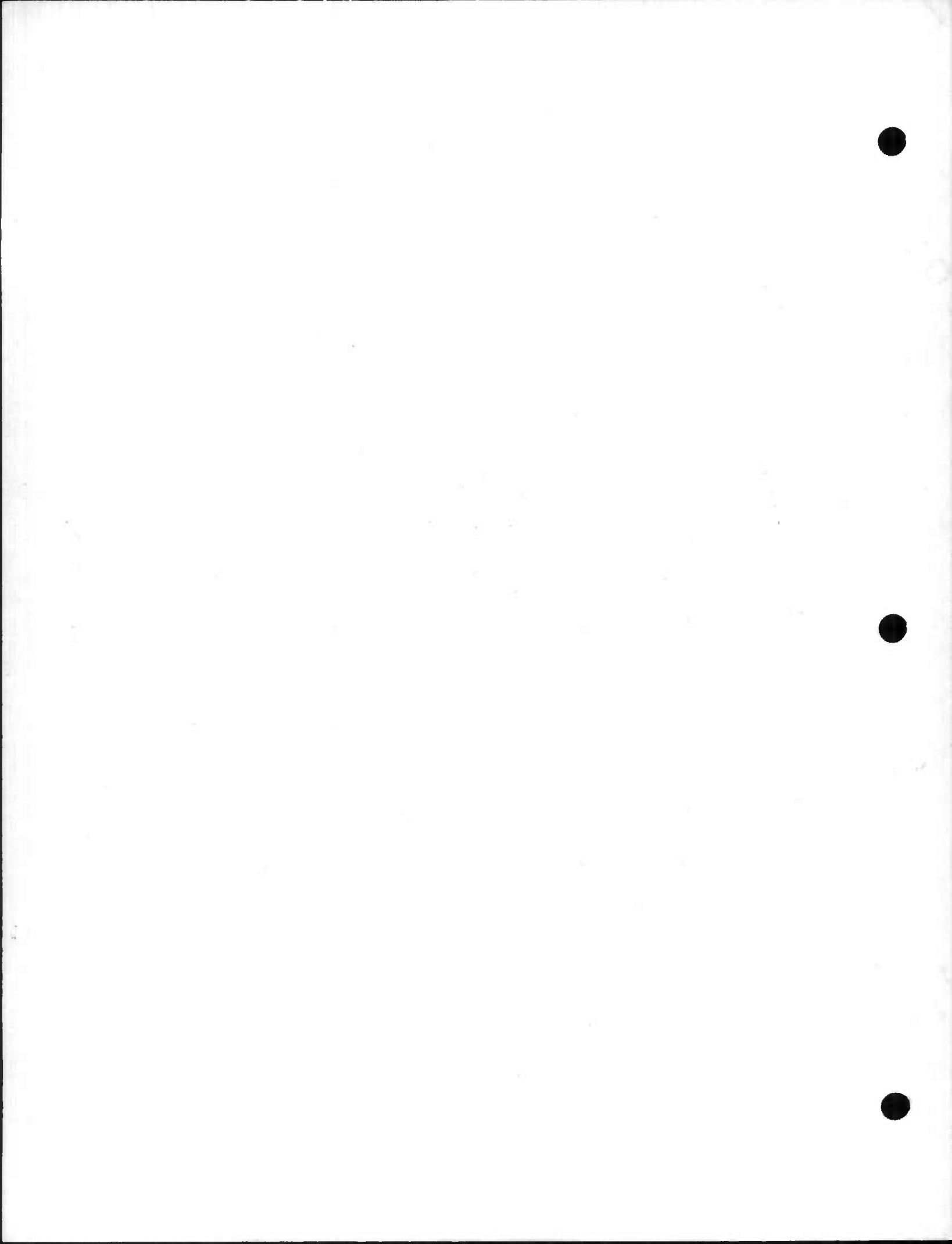
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - DECEDENT'S NAME (First, Middle, Last)		Geraldine E. Crook					2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 10:23 P.M.						
4. SOCIAL SECURITY NUMBER 219-26-4276		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug 27, 1922		8. BIRTHPLACE (State or Foreign Country) Va					
9a. FACILITY NAME (If not institution, give street and number) 3336 Avondale Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore					9c. COUNTY OF DEATH NA								
10a. STATE Md		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore					10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER 3336 Avondale Avenue							10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? U.S.A						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES					13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:					14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) N/A Unemployed					16b. KIND OF BUSINESS/INDUSTRY NA								
17. FATHER'S NAME (First, Middle, Last) Eddie Cam		18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Gray													
19a. INFORMANT'S NAME (Type/Print) Donald Wm Crook		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3336 Avondale Avenue Baltimore, Md 21215													
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ring Men Park					DATE 6/28/95		20c. LOCATION — City or Town, State Randallstown						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Gala March		22. NAME AND ADDRESS OF FACILITY March F.H. West 4300 Wabash Ave Baltimore, Md 21215													
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. <i>Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):															
b. _____ DUE TO (OR AS A CONSEQUENCE OF):															
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald Wm Crook, MD</i>		29c. LICENSE NUMBER D 36353					29d. DATE SIGNED (Month, Day, Year) ► 6/23/95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3319 York Boulevard Baltimore, Maryland 21215															
31. DATE FILED (Month, Day, Year) JUN 26 1995															



DIVISION OF VITAL RECORDS, P.O. BOX 687660

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

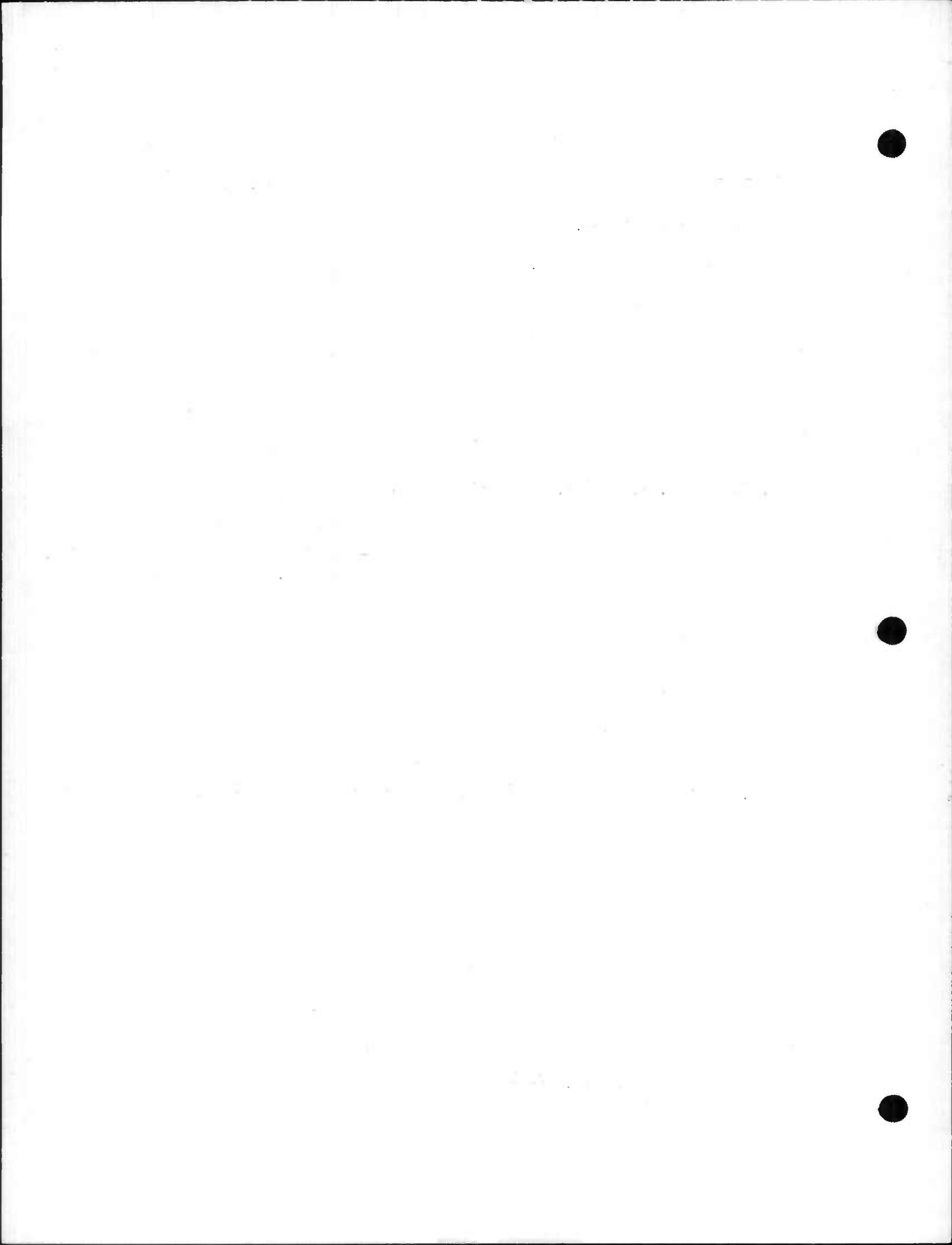
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR		Helen Rita Cooke													
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 215-09-9846		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 7, 1912	8. BIRTHPLACE (State or Foreign Country) Maryland								
9a. FACILITY NAME (If not institution, give street and number) Franklin Woods Nursing Home												9b. CITY, TOWN OR LOCATION OF DEATH Rossville	9c. COUNTY OF DEATH Baltimore		
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Edgemere		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 4536 Todd Point Lane				10f. ZIP CODE 21219		10g. CITIZEN OF WHAT COUNTRY? United States									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home									
17. FATHER'S NAME (First, Middle, Last) Stanislaus Waika						18. MOTHER'S NAME (First, Middle, Maiden Surname) Hedwig Kopera									
19a. INFORMANT'S NAME (Type/Print) Mr. Gilbert L. Cooke, Sr.						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4536 Todd Point Lane Edgemere, Maryland 21219									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery 6/23/95				DATE		20c. LOCATION — City or Town, State Baltimore, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Carcinoma, Breast DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____												Approximate Interval Between Onset and Death 3 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Superior Vena Cava Syndrome												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) In-pt. Hospice													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER W.D. Hakkarinen MD										29c. LICENSE NUMBER D08252	29d. DATE SIGNED (Month, Day, Year) ► 6-20-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) W.D. HAKKARINEN MD, FRANKLIN SQUARE HOSPITAL, BALTIMORE MD 21237												31. DATE FILED (Month, Day, Year) JUN 26 1995			
32. REGISTRAR'S SIGNATURE 															



DIVISION OF VITAL RECORDS, P.O. BOX 68760

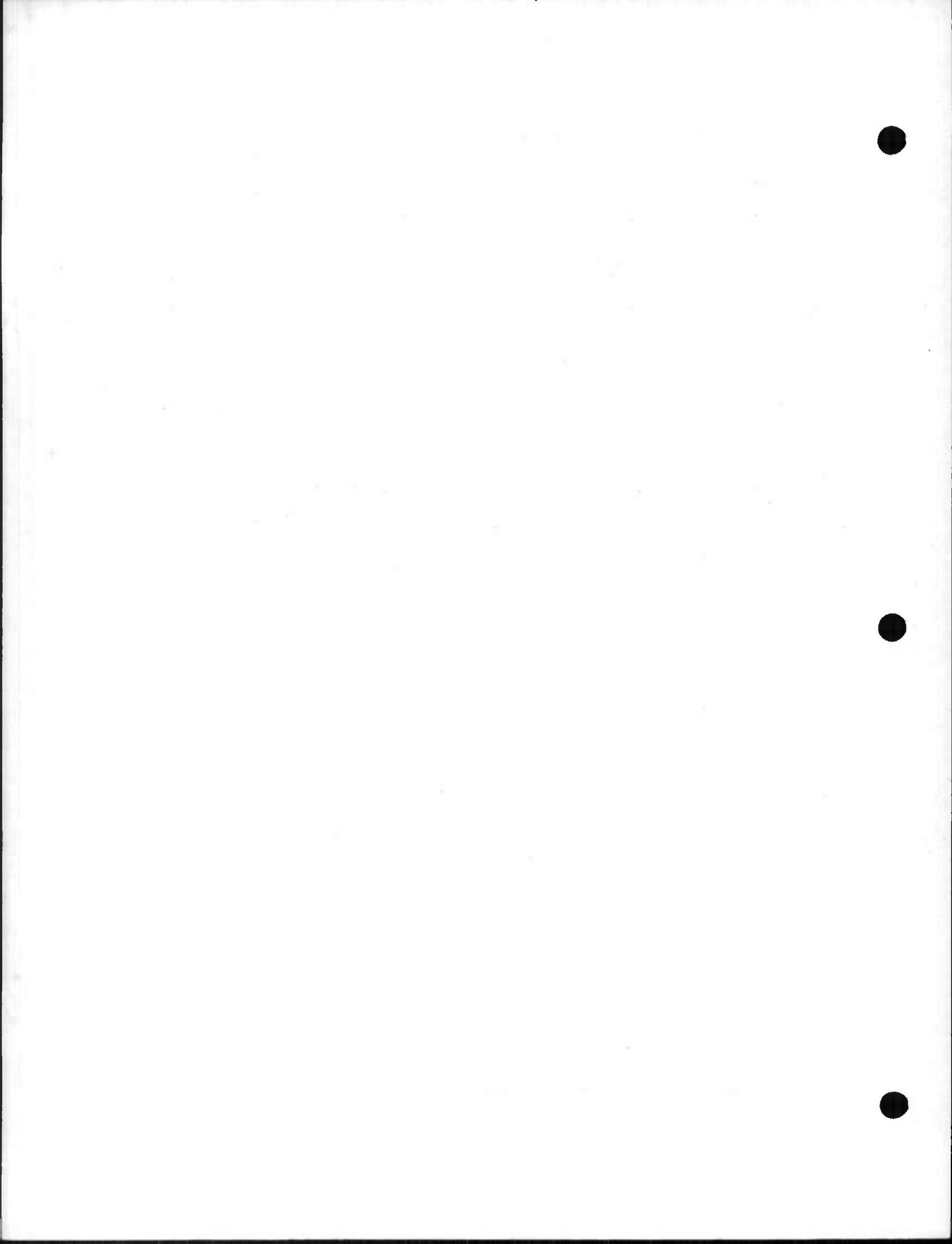
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. 95 19247	
1. DECEDENT'S NAME (First, Middle, Last) John Melvin Cunningham							2. DATE OF DEATH MONTH JUNE DAY 22, YEAR 1995		3. TIME OF DEATH 6:20 AM	
4. SOCIAL SECURITY NUMBER 212-28-6958		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec 21, 1932	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 1009 North Woodington Road				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH n/a		
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 YES 2 NO		
10e. STREET AND NUMBER 1009 North Woodington Road				10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th Grade		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter			16b. KIND OF BUSINESS/INDUSTRY Belvedere Construction Co					
17. FATHER'S NAME (First, Middle, Last) unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Nettie Hall						
19a. INFORMANT'S NAME (Type/Print) Nellie Cunningham				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1009 N. Woodington Rd Baltimore, Maryland 21229						
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park				20c. LOCATION — City or Town, State June 28 Baltimore County, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kevin Parker				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC ADENOCARCINOMA DUE TO (OR AS A CONSEQUENCE OF): UNKNOWN PRIMARY TUMOR Approximate Interval Between Onset and Death months										
b. UNKNOWN PRIMARY TUMOR DUE TO (OR AS A CONSEQUENCE OF): c. UNKNOWN PRIMARY TUMOR DUE TO (OR AS A CONSEQUENCE OF): d. UNKNOWN PRIMARY TUMOR DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA				OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURRED				
27. MANNER OF DEATH 1 Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 7 Could not be determined 4 Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER MAHESH S. OCHANAY, M.D.		29c. LICENSE NUMBER D-40521		29d. DATE SIGNED (Month, Day, Year) ► June 23, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MAHESH S. OCHANAY, M.D.		31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Jahn A. Schaefer, R.R.						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

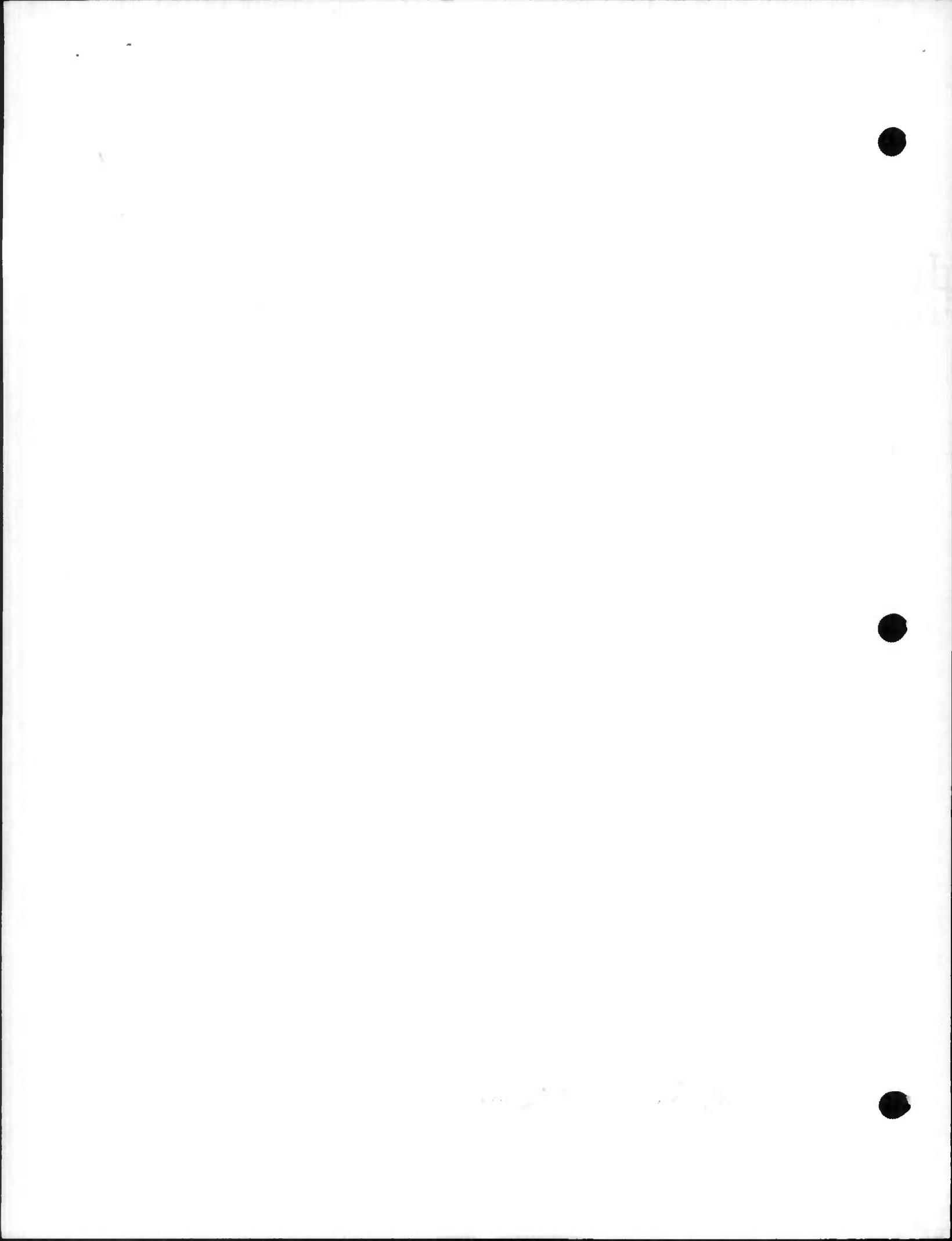
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 20, 1995										3. TIME OF DEATH 9 a.m.	
1. DECEDENT'S NAME (First, Middle, Last) Jennie Anne Cerniglia													
4. SOCIAL SECURITY NUMBER 219-22-4139		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	7. DATE OF BIRTH (Month, Day, Year) June 24, 1928		8. BIRTHPLACE (State or Foreign Country) Pennsylvania			
9a. FACILITY NAME (If not institution, give street and number) 3801 Byxbee Road												9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	9c. COUNTY OF DEATH Baltimore
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Randallstown						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 3801 Byxbee Road						10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify				14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cosmetician				16b. KIND OF BUSINESS/INDUSTRY J. C. Penney, Co. Inc.							
17. FATHER'S NAME (First, Middle, Last) Stanley Budzinski						18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Smellgus							
19a. INFORMANT'S NAME (Type/Print) Vincent J. Cerniglia						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3801 Byxbee Road Randallstown, Maryland 21133							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Memorial Park 6/23/95				20c. LOCATION — City or Town, State Sykesville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Joseph J.W. Reilner						22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd Randallstown, MD 21133-4784							
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Approximate Interval Between Onset and Death	
a. Recurrent Organic Gingivitis. DUE TO (OR AS A CONSEQUENCE OF):													
b. Cardiorespiratory Arrest DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. 													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. LICENSE NUMBER 220637										29d. DATE SIGNED (Month, Day, Year) ► 6/21/94	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Francis C. Oranbie, M.D. 6569 N. Charles St. Baltimore 21229													
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Gale A. Walker, R.R.										DHMH-16 Rev 1/99	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

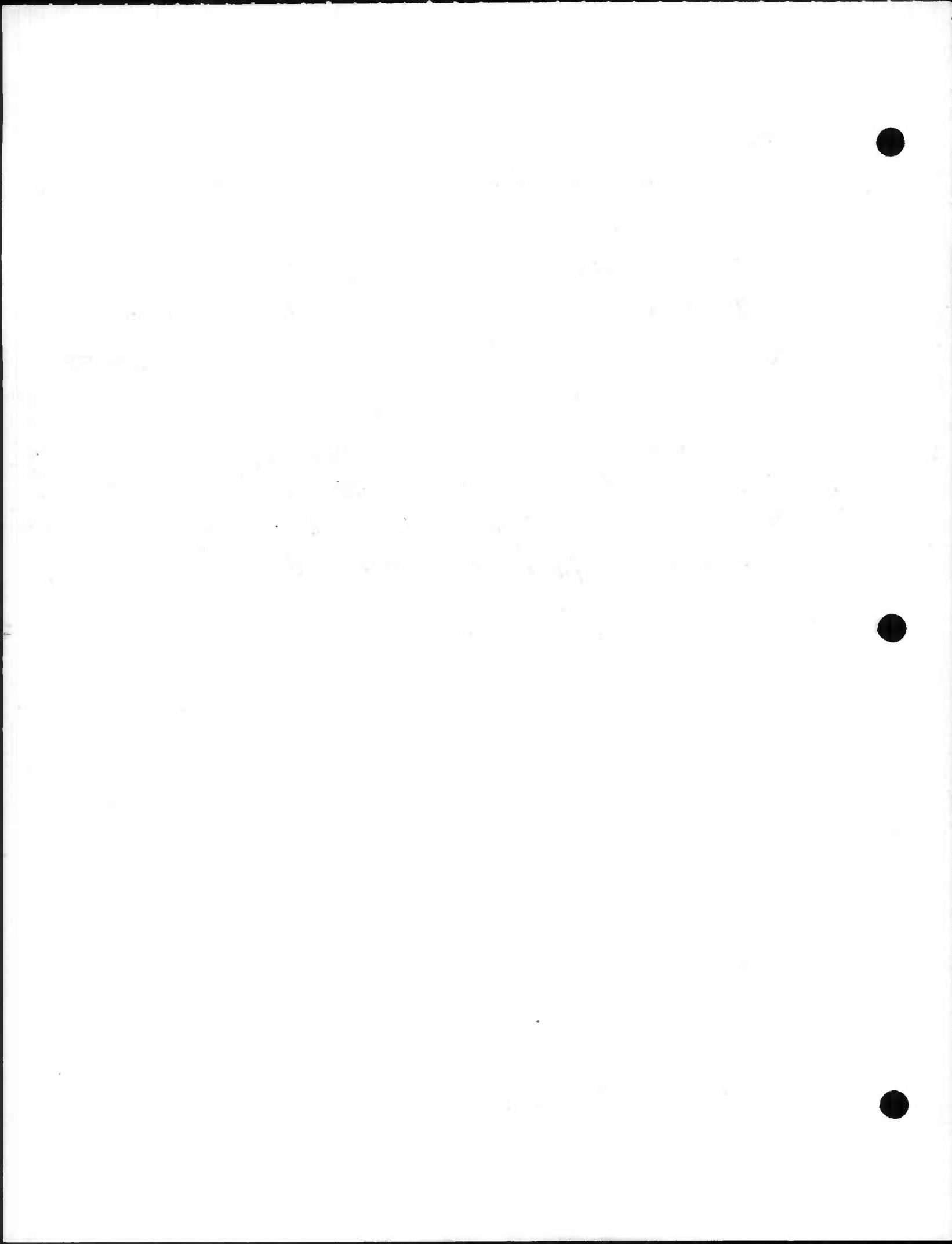
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH								REG. NO.
1. DECEDENT'S NAME (First, Middle, Last)		FAVETTA MABEL CHANCE				2. DATE OF DEATH MONTH 6 DAY 18 YEAR 95		3. TIME OF DEATH 0050
4. SOCIAL SECURITY NUMBER 286-18-2814		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		7. DATE OF BIRTH Month, Day, Year Aug. 28, 1920		8. BIRTHPLACE (State or Foreign Country) Ohio
9a. FACILITY NAME (If not institution, give street and number) MED POINT NURSING HOME		9b. CITY, TOWN OR LOCATION OF DEATH ELKTON				9c. COUNTY OF DEATH CECIL		
10a. STATE MD.		10b. COUNTY CECIL		10c. CITY, TOWN OR LOCATION PORT DEPOSIT				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 57 FOX FIRE DR.						10f. ZIP CODE 21904		10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES CLERK				16b. KIND OF BUSINESS/INDUSTRY RETAIL SALES		
17. FATHER'S NAME (First, Middle, Last) UNKNOWN		18. MOTHER'S NAME (First, Middle, Maiden Surname) MARGARET ORICK						
19a. INFORMANT'S NAME (Type/Print) GERALD W. CHANCE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6255 GLADE AVE. CINCINNATI OHIO 45230						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) OAKHILL CEM. 6-23-95 SPRINGDALE, OHIO				DATE	20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE/LICENSEE Gloria Steele Jr.		22. NAME AND ADDRESS OF FACILITY SKARDA FH. 2829 HUDSON ST. BALTIMORE, MD. 21224						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. CARCINOMA OF LUNG WITH BRAIN/BONE METS. DUE TO (OR AS A CONSEQUENCE OF):								
Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____ o. _____ p. _____ q. _____ r. _____ s. _____ t. _____ u. _____ v. _____ w. _____ x. _____ y. _____ z. _____								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Suresh Dhantani MD		29c. LICENSE NUMBER D45344				29d. DATE SIGNED (Month, Day, Year) 6/18/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURESH DHANTANI, MD, 20 CRAIGTOWN RD, PORT DEPOSIT, MD 21904								
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE John Andrew Parker						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

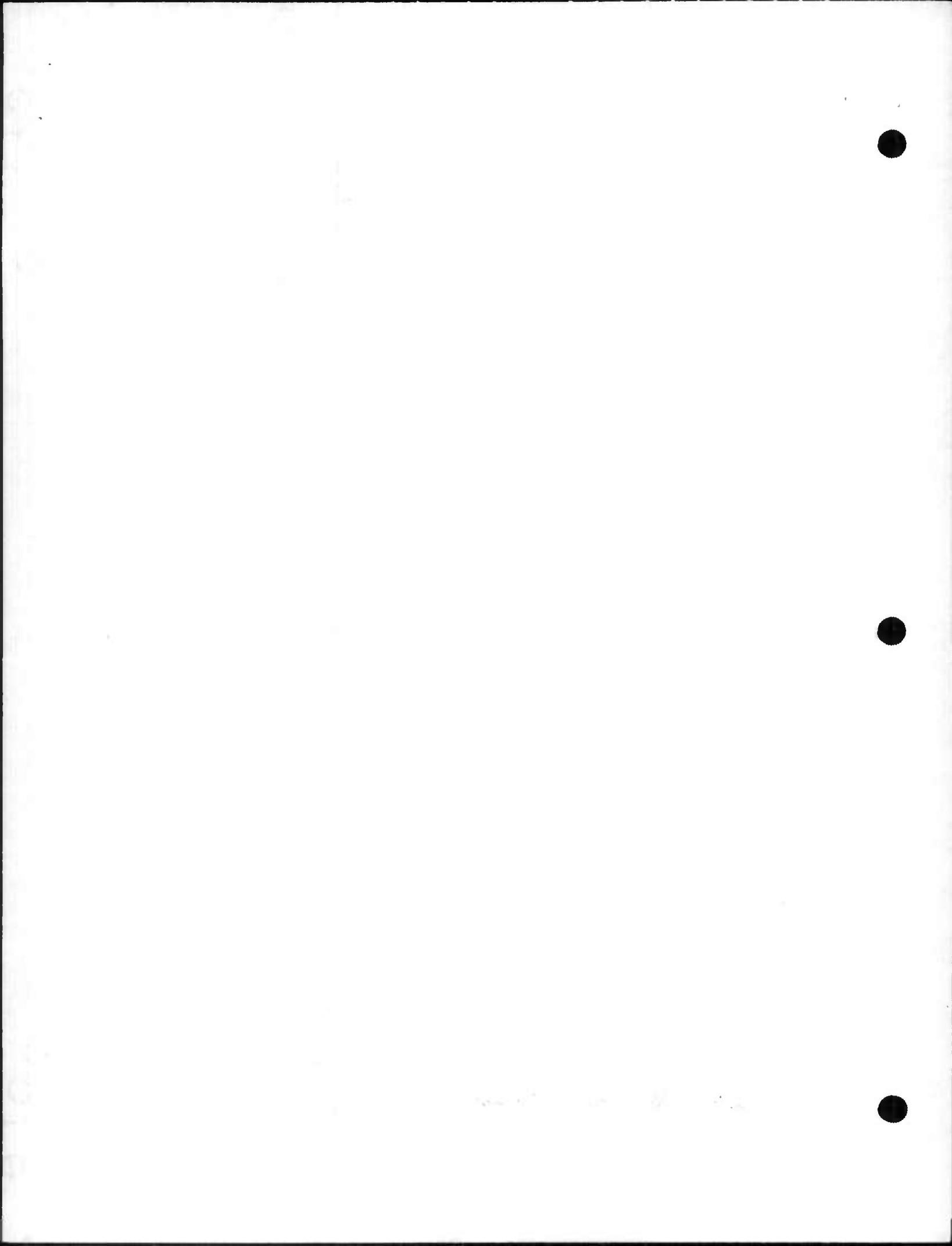
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										3. TIME OF DEATH			
Clifton L. Dawson												June 22 1995	2250 M		
4. SOCIAL SECURITY NUMBER 226-20-2641		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTHS		DAYS		HOURS	MIN.		
9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center												7. DATE OF BIRTH (Month, Day, Year) Dec. 28, 1917		8. BIRTHPLACE (State or Foreign Country) Virginia	
9b. CITY, TOWN OR LOCATION OF DEATH Randallstown												9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT															
10a. STATE Maryland	10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Marriottsville										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 6904 Pine Hill Ct.					10f. ZIP CODE 21104					10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tire Builder			16b. KIND OF BUSINESS/INDUSTRY Schuniut Rubber Co.										
17. FATHER'S NAME (First, Middle, Last) Unknown					18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown										
19a. INFORMANT'S NAME (Type/Print) Susan Memmert					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6903 Pine Hill Ct. Marriottsville, MD 21104										
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Service			DATE 6/24		20c. LOCATION — City or Town, State Hampstead, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jasneem B. Salehain</i>					22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute Myocardiac Infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i>circum</i>															
b. _____															
c. _____															
d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HYPERTENSION</i> <i>CHRONIC OBSTRUCTIVE Pulmonary Disease</i>															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jasneem Salehain MD</i>		29c. LICENSE NUMBER D28577		29d. DATE SIGNED (Month, Day, Year) <i>► 6/24/95</i>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JASNEEM LAKHANI, 7220 PARK HEIGHTS Ave Bldg 1021208</i>		31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i>		32. REGISTRAR'S SIGNATURE <i>Jasneem Salehain</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

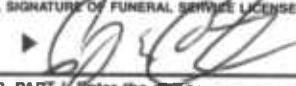
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

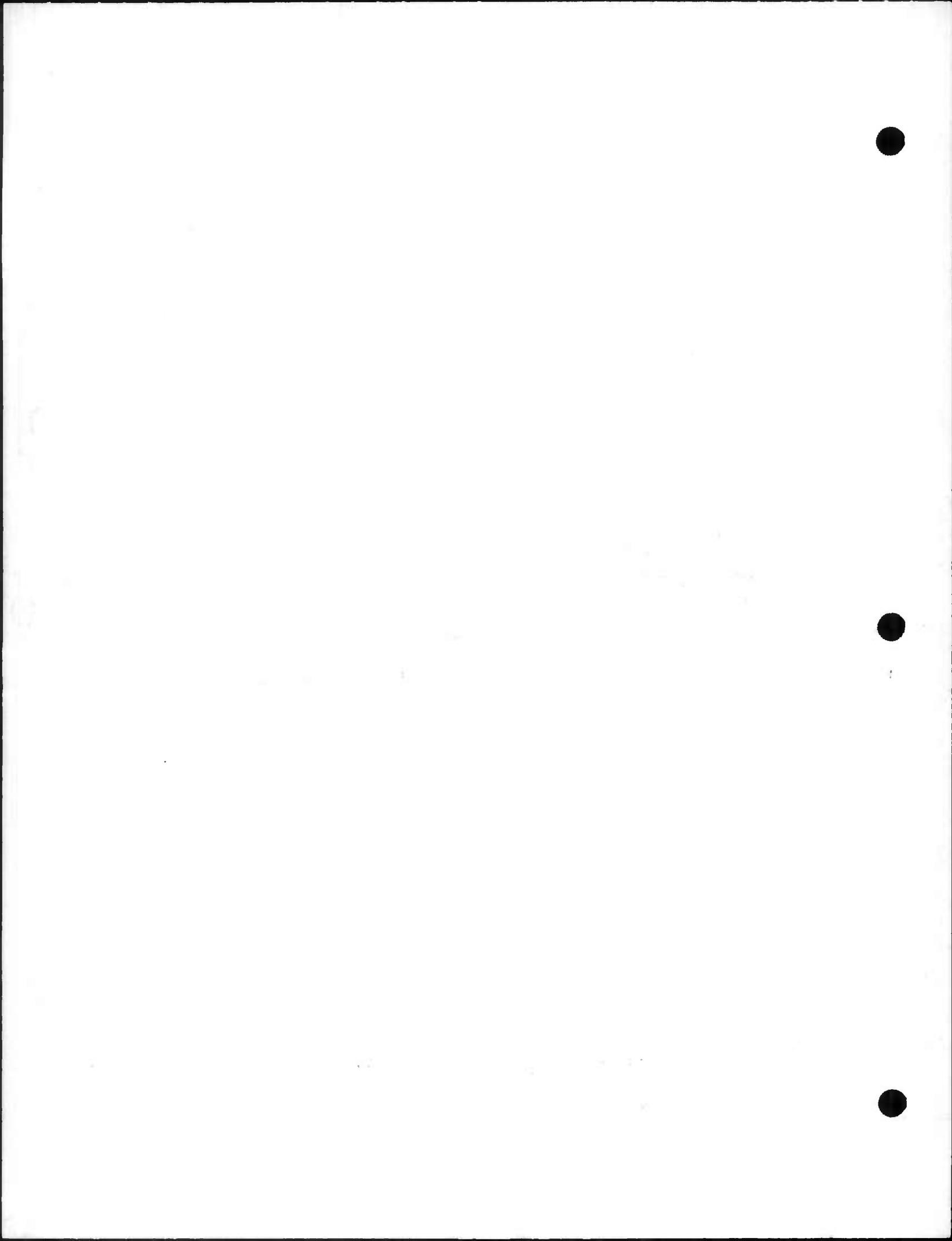
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Pauline DIMLER										2. DATE OF DEATH MONTH DAY YEAR June 20, 1995	3. TIME OF DEATH 8:55 a.m.
4. SOCIAL SECURITY NUMBER 380164819		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) FEB 12, 1923			8. BIRTHPLACE (State or Foreign Country) DELAWARE
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH ROSSVILLE	9c. COUNTY OF DEATH Baltimore County
10e. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1320 EVERING AVENUE										10f. ZIP CODE 21237	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY OWN HOME					
17. FATHER'S NAME (First, Middle, Last) CAMILLO LANCI										18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY GRIFFITH	
19a. INFORMANT'S NAME (Type/Print) ERNEST M. LANCI					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13167 JOBIN ST. SOUTH GATE, MICH. 48195						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) LORRIANE PARK			DATE 6/26	20c. LOCATION — City or Town, State BALTIMORE, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTO, MD 21237	
23. PART I. Enter the illnesses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Bilateral Pneumonia/Respiratory Failure</u> DUE TO (OR AS A CONSEQUENCE OF):										10 days	
b. <u>Ischemic Bowel Disease</u> DUE TO (OR AS A CONSEQUENCE OF):											
c. <u>Idiopathic Thrombocytosis</u> DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D28949				29d. DATE SIGNED (Month, Day, Year) June 20, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Panayiotis Baltatzis, M.D. 1232 Race Road Suite 202, Baltimore, MD 21237										31. DATE FILED (Month, Day, Year) JUN 26 1995	

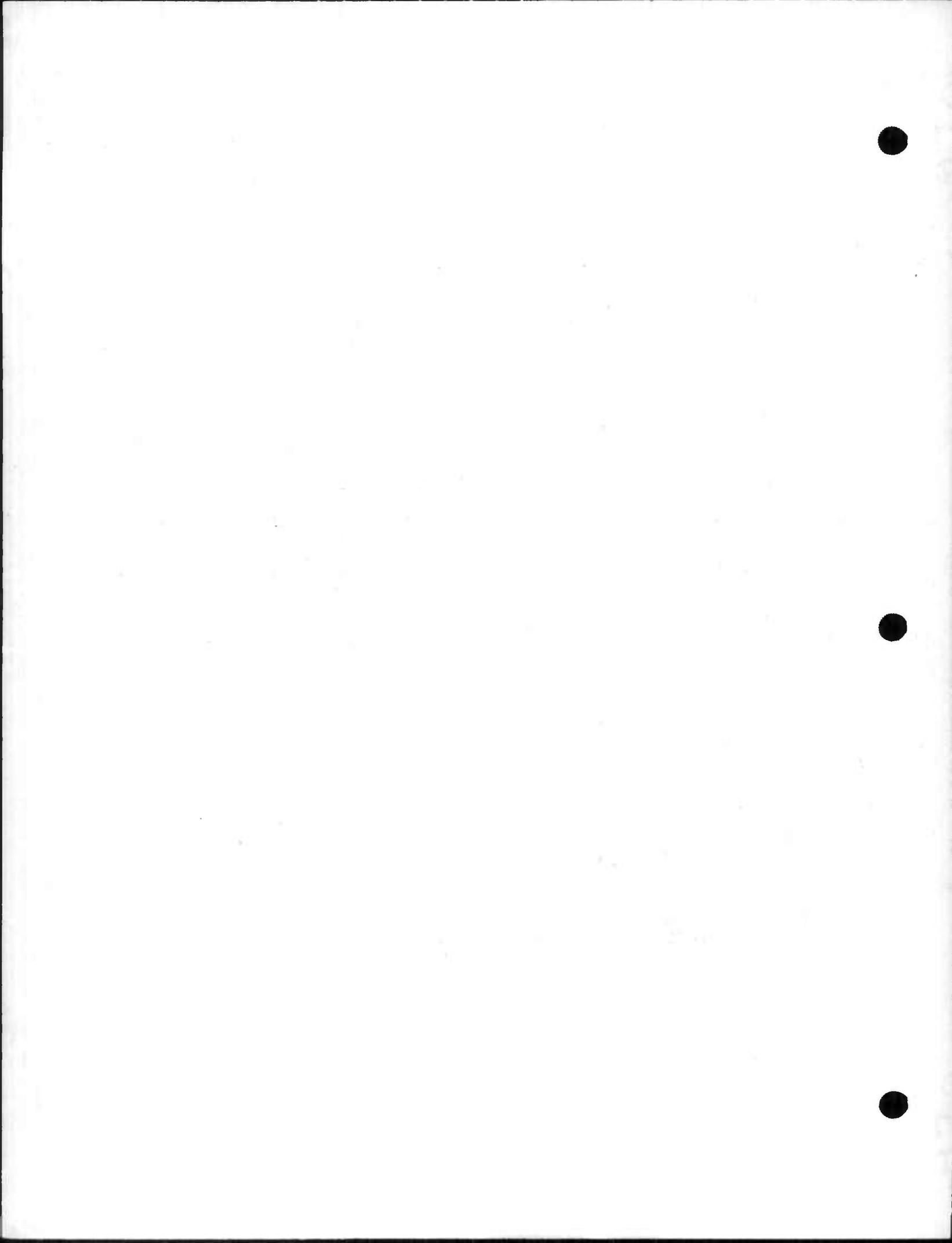


95 19252

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) INEZ PEANNIE EVANS												2. DATE OF DEATH MONTH JUNE DAY 20, 1995 YEAR 1995	3. TIME OF DEATH 20:30 P M
4. SOCIAL SECURITY NUMBER 214-56-3813			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 47 YRS.	7. IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	8. BIRTHPLACE (State or Foreign Country) Md						
9a. FACILITY NAME (If not institution, give street and number) 2127 DIVISION ST.			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH N/A						
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STATE Md	10f. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore				10g. CITIZEN OF WHAT COUNTRY? USA							
10e. STREET AND NUMBER 2127 Division Street					10f. ZIP CODE =21217	14. RACE — American Indian, Black, White, etc. Specify: Black							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			16b. KIND OF BUSINESS/INDUSTRY Laundry				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th grade			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer			16b. KIND OF BUSINESS/INDUSTRY Laundry							
17. FATHER'S NAME (First, Middle, Last) Louis Evans					18. MOTHER'S NAME (First, Middle, Maiden Surname) Izloa Carter								
19a. INFORMANT'S NAME (Type/Print) Nathaniel Evans					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4002 Glengyle Avenue Baltimore, Md 21215								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park			DATE 62795	20c. LOCATION — City or Town, State Randallstown, Md				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dola March</i>					22. NAME AND ADDRESS OF FACILITY March F?H West 4300 Wabash Avenue Balto, Md 21215								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>b. Hypertensive Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>c. Diabetes</i> DUE TO (OR AS A CONSEQUENCE OF): <i>d.</i>													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obesity</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? XX YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) JUNE 21, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Hughes A. O'Leary Jr. 111 Penn Street, Baltimore, Maryland 21201</i>		31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REQUESTED SIGNATURE <i>John A. O'Leary</i>									



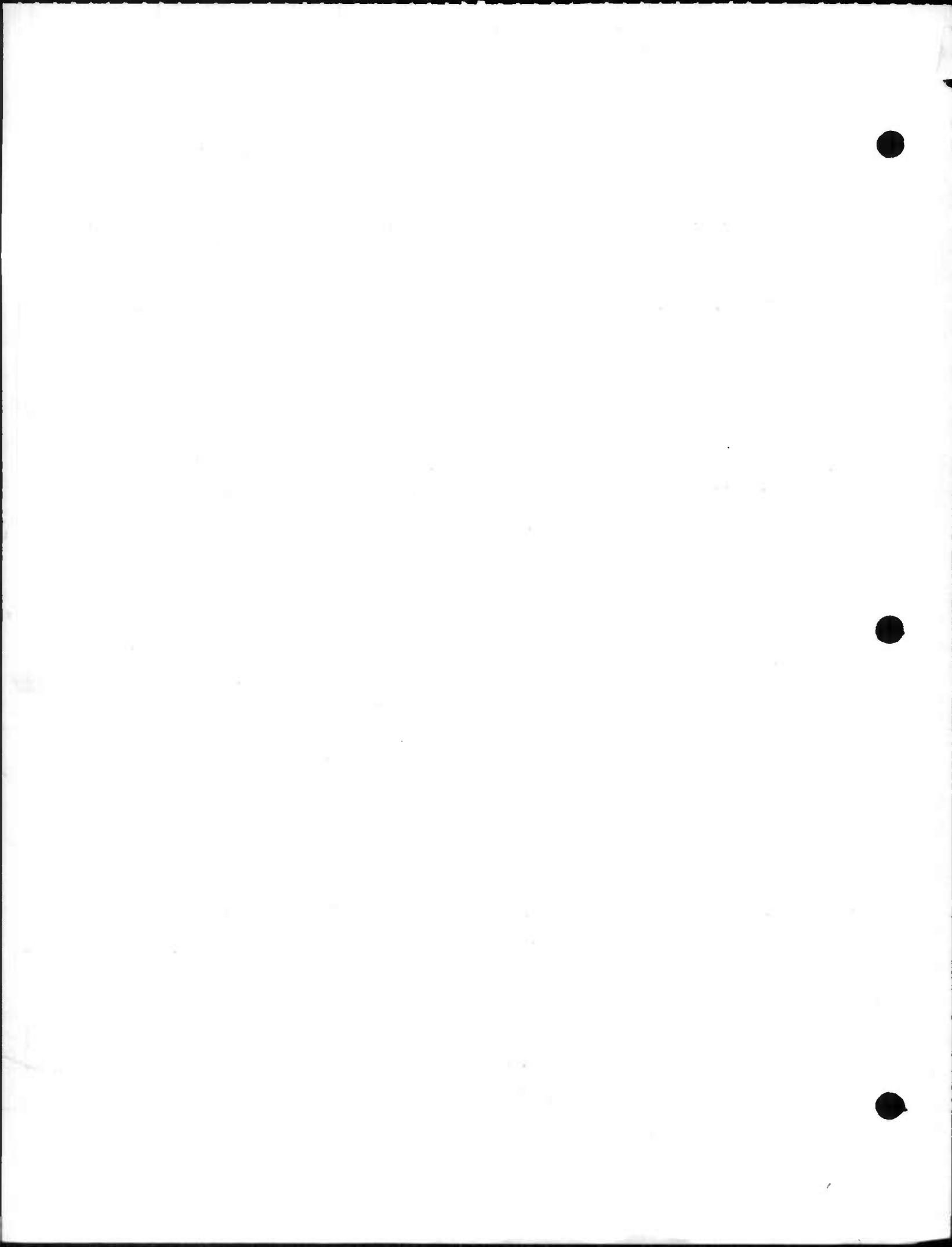
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR JUNE 13, 1995								3. TIME OF DEATH 0936 A. M.	
1. DECEASED'S NAME (First, Middle, Last) SAMUEL FOX										7. DATE OF BIRTH (Month, Day, Year) MAY 20, 1901	
4. SOCIAL SECURITY NUMBER 052-05-0998		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) NEW YORK			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH BALTIMORE CITY											
RESIDENCE OF DECEASED											
10a. STATE MARYLAND	10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 8203 TALL CHIMNEY COURT										10f. ZIP CODE 21208	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH GRADE		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) SALES				16b. KIND OF BUSINESS/INDUSTRY SELF-EMPLOYED					
17. FATHER'S NAME (First, Middle, Last) UNKNOWN										18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN	
19a. INFORMANT'S NAME (Type/Print) CHARLENE COHEN					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8203 TALL CHIMNEY COURT-BALTIMORE, MD 21208						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MONTEFIORE CEMETERY				DATE 6/15	20c. LOCATION — City or Town, State LONG ISLAND, N.Y.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie O. Shannon</i>					22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVENUE-BALTIMORE, MD 21229						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death	
<p>a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF)</p> <p>b. <i>Subcapital Fracture Right Hip</i> DUE TO (OR AS A CONSEQUENCE OF)</p> <p>c. <i>Parkinson's Disease</i> DUE TO (OR AS A CONSEQUENCE OF)</p> <p>d. <i>Failure to Thrive</i> DUE TO (OR AS A CONSEQUENCE OF)</p>										<i>Chronic</i> <i>6 Days</i> <i>Years</i> <i>Months</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Dementia, Anxiety</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								24c. LOCATION (Street and Number or Rural Route Number, City or Town, State) North Oaks 725 Mt. W. Bon Lane Md	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6-7-95		28b. TIME OF INJURY 1230 PM		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED Fell			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <i>Mark S. Williams, DO</i>		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Nursing Home								28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Beth	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark S. Williams, DO</i>		29c. LICENSE NUMBER 05008141-L								29d. DATE SIGNED (Month, Day, Year) 6-19-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mark S. Williams, DO, Sinai Hospital of Baltimore, 2401 W. Belvedere</i>											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>John Shuster-Randall</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
CHESTER GIGLIOTTI										JUNE 20 1995	1:53 PM
4. SOCIAL SECURITY NUMBER 213 20 4026		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year) Feb. 15, '11	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
9a. FACILITY NAME Harbor Hospital Center Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Brooklyn Park Baltimore		9c. COUNTY OF DEATH Anne Arundel N/A							
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Columbia		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 9473 Hickory Limb				10f. ZIP CODE 21045		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Owner		16b. KIND OF BUSINESS/INDUSTRY Restaurant/Tavern							
17. FATHER'S NAME (First, Middle, Last) John Gigliotti		18. MOTHER'S NAME (First, Middle, Maiden Surname) Grazia Seriani									
19a. INFORMANT'S NAME (Type/Print) John Gigliotti		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9473 Hickory Limb Columbia, MD 21045									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE 6/24	20c. LOCATION — City or Town, State Catonsville, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna M. Bramieuski</i>		22. NAME AND ADDRESS OF FACILITY George J. Gonc Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225									
23. PART I. Enter the disease(s), or condition(s) that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		s. HYPERTENSIVE AND ARTERIOSCLEROTIC CARDIO- DUE TO (OR AS A CONSEQUENCE OF): b. VASCULAR DISEASE. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									
Approximate Interval Between Onset and Death											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE PULMONARY DISEASE.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Gimbel</i>		29c. LICENSE NUMBER D 41807		29d. DATE SIGNED (Month, Day, Year) ► JUNE 21 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. JEFFREY Gimbel 3001 S. Hanover ST. Balt., Md. 21230		31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Jeanne L. Miller</i>							

2003-09-01

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

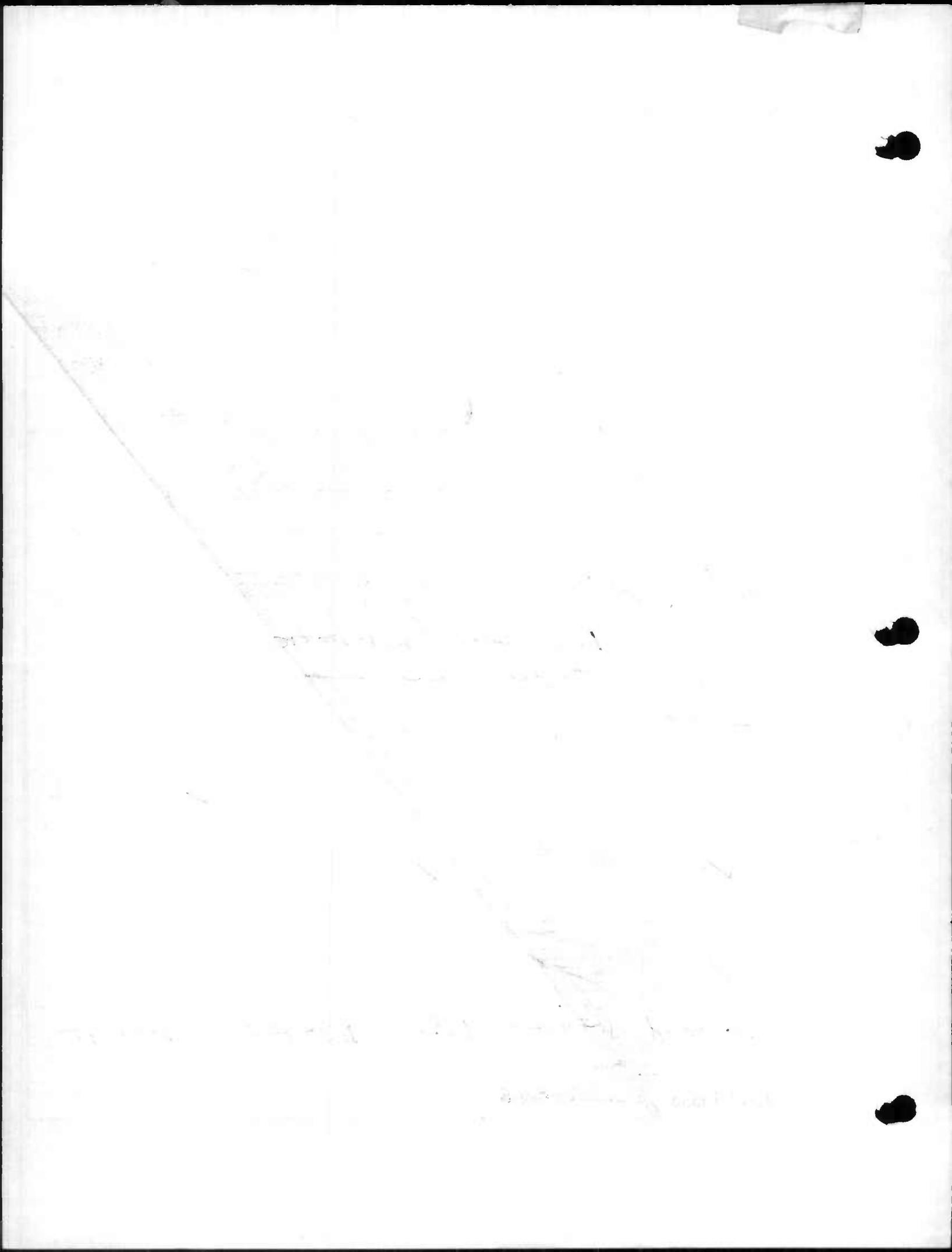
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19255

1. DECEASED'S NAME (First, Middle, Last) ANTHONY JOHN GIGLIOTTI				2. DATE OF DEATH MONTH DAY YEAR June 21, 1995	3. TIME OF DEATH 10:30 A.M.	
4. SOCIAL SECURITY NUMBER 216-16-6192		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. Dec. 5, 1920	7. DATE OF BIRTH (Month, Day, Year) Dec. 5, 1920	8. BIRTHPLACE (State or Foreign Country) Italy
9e. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore
10e. STATE Maryland		10b. COUNTY n/a	10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 X YES 2 □ NO
10e. STREET AND NUMBER 4309 Seidel Avenue				10f. ZIP CODE 21206	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16e. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)		16b. KIND OF BUSINESS/INDUSTRY Service Manager Auto Repair		
17. FATHER'S NAME (First, Middle, Last) John Gigliotti				18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Fragala		
19a. INFORMANT'S NAME (Type/Print) Mr. Sam J. Gigliotti				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7928 Westmoreland Avenue Baltimore, Maryland 21234		
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) .		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery		DATE 6/24/95	20c. LOCATION — City or Town, State Baltimore Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Michael Ruck				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road 21214		
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung cancer, metastatic DUE TO (OR AS A CONSEQUENCE OF): Tobacco use						
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)		26. PLACE OF DEATH (Check only one) 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 □ YES 2 □ NO 28d. DESCRIBE HOW INJURY OCCURRED		
27. MANNER OF DEATH 1 X Natural 5 □ Pending investigation 2 □ Accident 3 □ Suicide 4 □ Homicide		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Howard Steiner MD		
29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER Howard Steiner MD		29c. LICENSE NUMBER A 38 403		29d. DATE SIGNED (Month, Day, Year) ► 6-22-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard Steiner, M.D. Suite 512 Russell Morgan Building						
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE John Shuler-Kastell				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

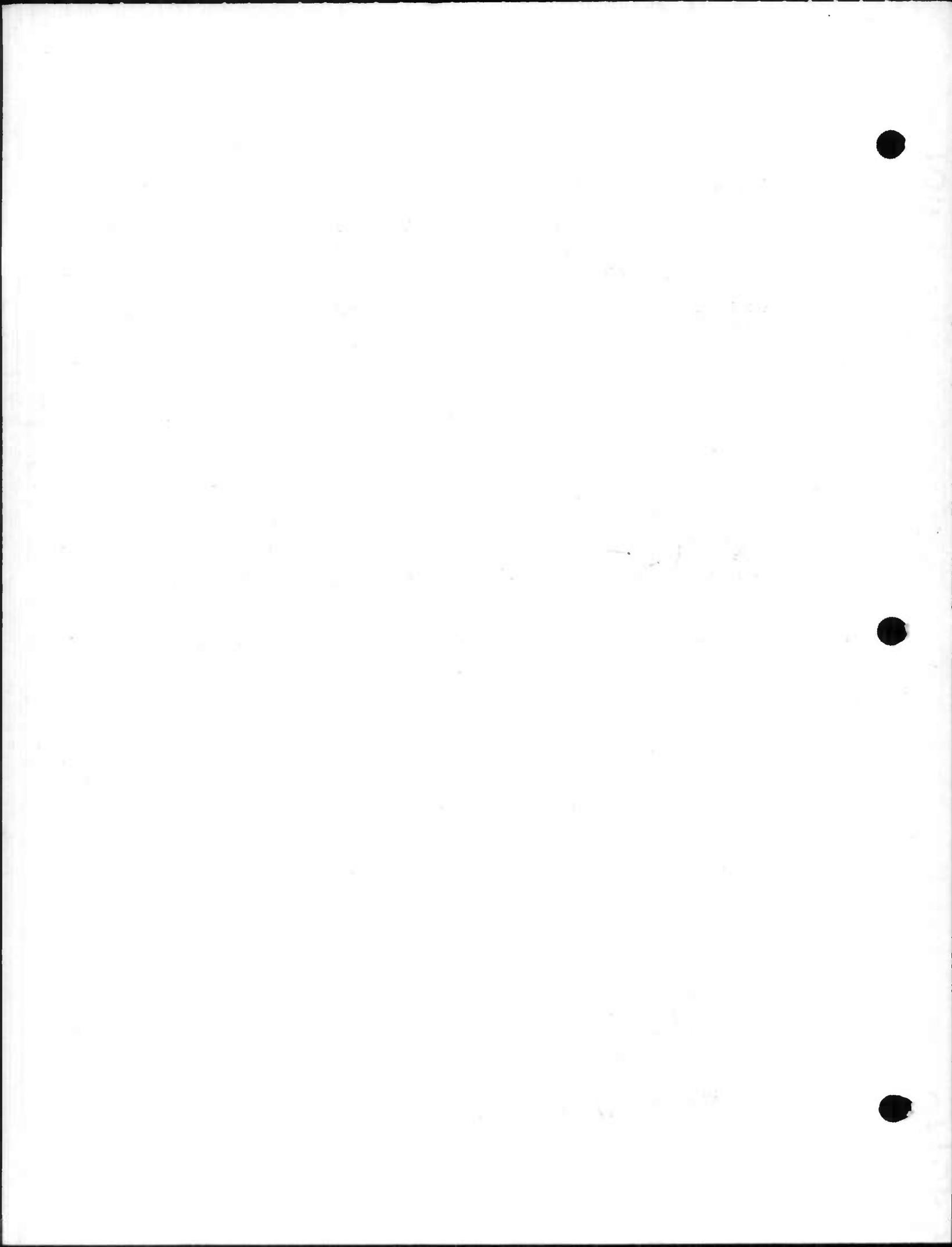
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Rosa Belle Thompson Gaskins										June 21, 1995	7:45 A.M.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.			7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
217-07-6960		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	86 YRS.	MONTHS	DAYS	HOURS	MIN.	June 8, 1909		South Carolina	
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	
Mind's Ease - 4219 Buckskin Lake Drive Ellicott City										9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT										Howard	
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Maryland	Howard			Ellicott City							
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
4219 Buckskin Lake Drive				21042				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)		College (1-4 or 5+) College 2				Accountant				Dept of Correction	
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
John Thompson, Sr.										Emma	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Robert J. Wilson		5533 Westward Drive Virginia Beach, VA 23467								P.O. Box 64156	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State					
		Arthitus Memorial Park				June 27 Baltimore County, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. K. Emery Jr.</i>										22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Alzheimer's Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>										3wks.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Decubitus Ulcers of Feet</i> <i>Gastric tube Placement.</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one)		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>Group Home</i>									
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide											
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month, Day, Year) <i>06/23/95</i>	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Iris L. Davis MD.</i>										29c. LICENSE NUMBER <i>D44854</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i>	
IRIS L. DAVIS 861 PARK AVE, BALT, MD 21201										32. REGISTRAR'S SIGNATURE <i>J. Davis, R.R.</i>	



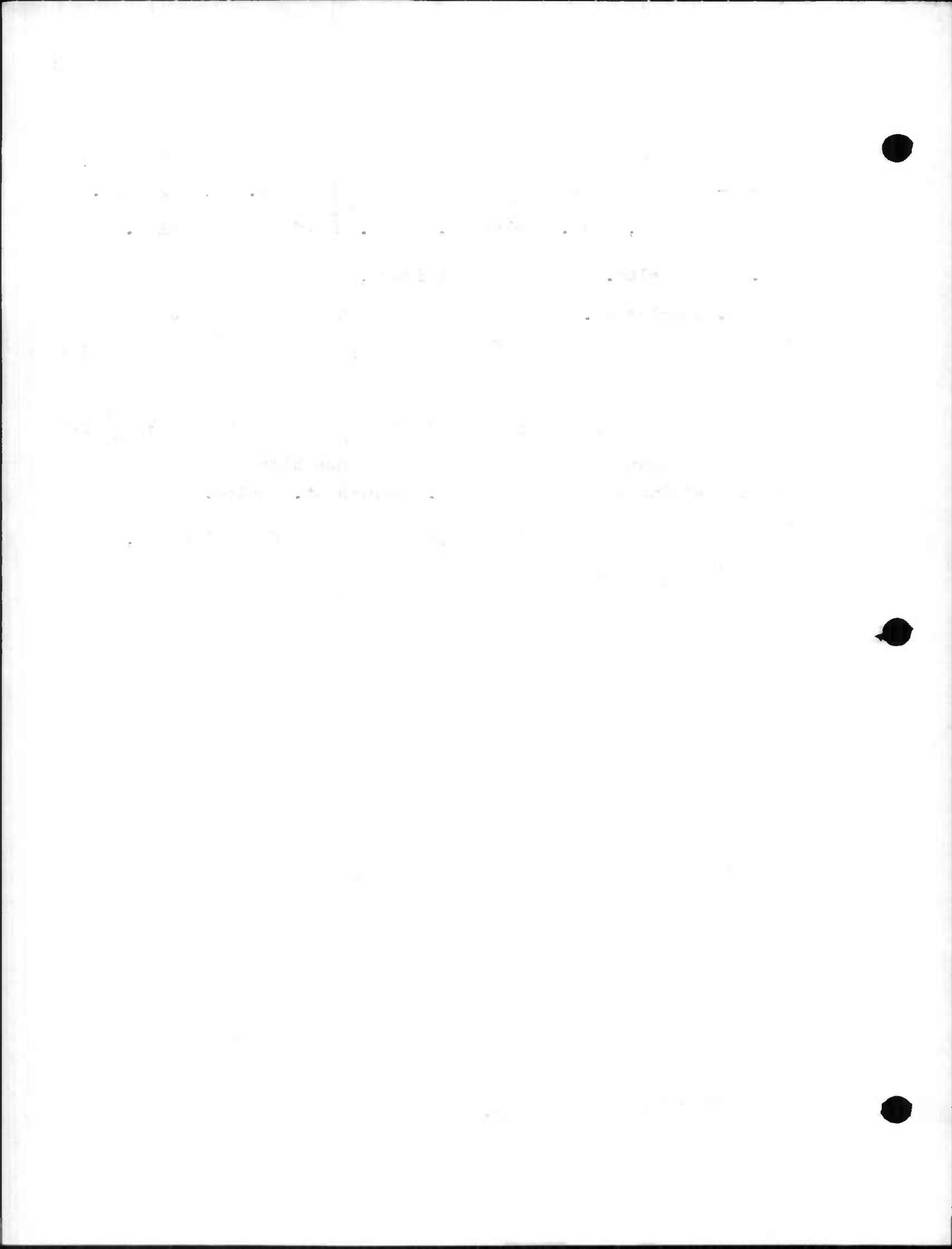
DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 5 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or if item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

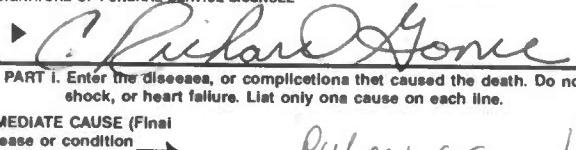
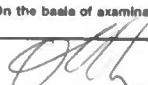
1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
						June 22 1995	1:17 p.m.		
1. DECEASED'S NAME (First, Middle, Last) Mary Lauretta Hamman						7. DATE OF BIRTH (Month, Day, Year) Nov. 24, 1902	8. BIRTHPLACE (State or Foreign Country) MD.		
4. SOCIAL SECURITY NUMBER 153-44-8974		5. SEX 1 □ M 2 X F	6. AGE (In yrs. last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	9. FACILITY NAME (If not institution, give street and number) Villa Assumpta, 6401 N. Charles St.			9b. CITY, TOWN OR LOCATION OF DEATH Balto. MD 21212	9c. COUNTY OF DEATH Balto.
10a. STATE MD.		10b. COUNTY Balto.		10c. CITY, TOWN OR LOCATION Baltimore, MD 21212			10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO		
10e. STREET AND NUMBER 6401 N. Charles St.		10f. ZIP CODE 21212			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS X Never Married 2 □ Married 3 □ Widowed 4 □ Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) R.S. in Edje teacher			16b. KIND OF BUSINESS/INDUSTRY elementary, business school				
17. FATHER'S NAME (First, Middle, Last) August Hamman		18. MOTHER'S NAME (First, Middle, Maiden Surname) Josephine Thoben			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6401 N. Charles St. Balto. MD 21212				
19a. INFORMANT'S NAME (Type/Print) Bernice Feilinger		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Villa Maria			DATE	20c. LOCATION — City or Town, State 6/26 Glen Arm, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Maryland 21212							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. DUE TO (OR AS A CONSEQUENCE OF): Acute myocardial infarction			Approximate Interval Between Onset and Death 8				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic coronary artery disease	c. DUE TO (OR AS A CONSEQUENCE OF):			d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? X 1 □ YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)							
27. MANNER OF DEATH X 1 □ Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. INJURY AT WORK? 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D15871 MD			29d. DATE SIGNED (Month, Day, Year) ► 6/22/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LAWRENCE BOAS, MD 54 SCOTT ADAM RD. COCKEYSVILLE, MD 21030		32. REGISTRAR'S SIGNATURE 							
31. DATE FILED (Month, Day, Year) JUN 2 6 1995									

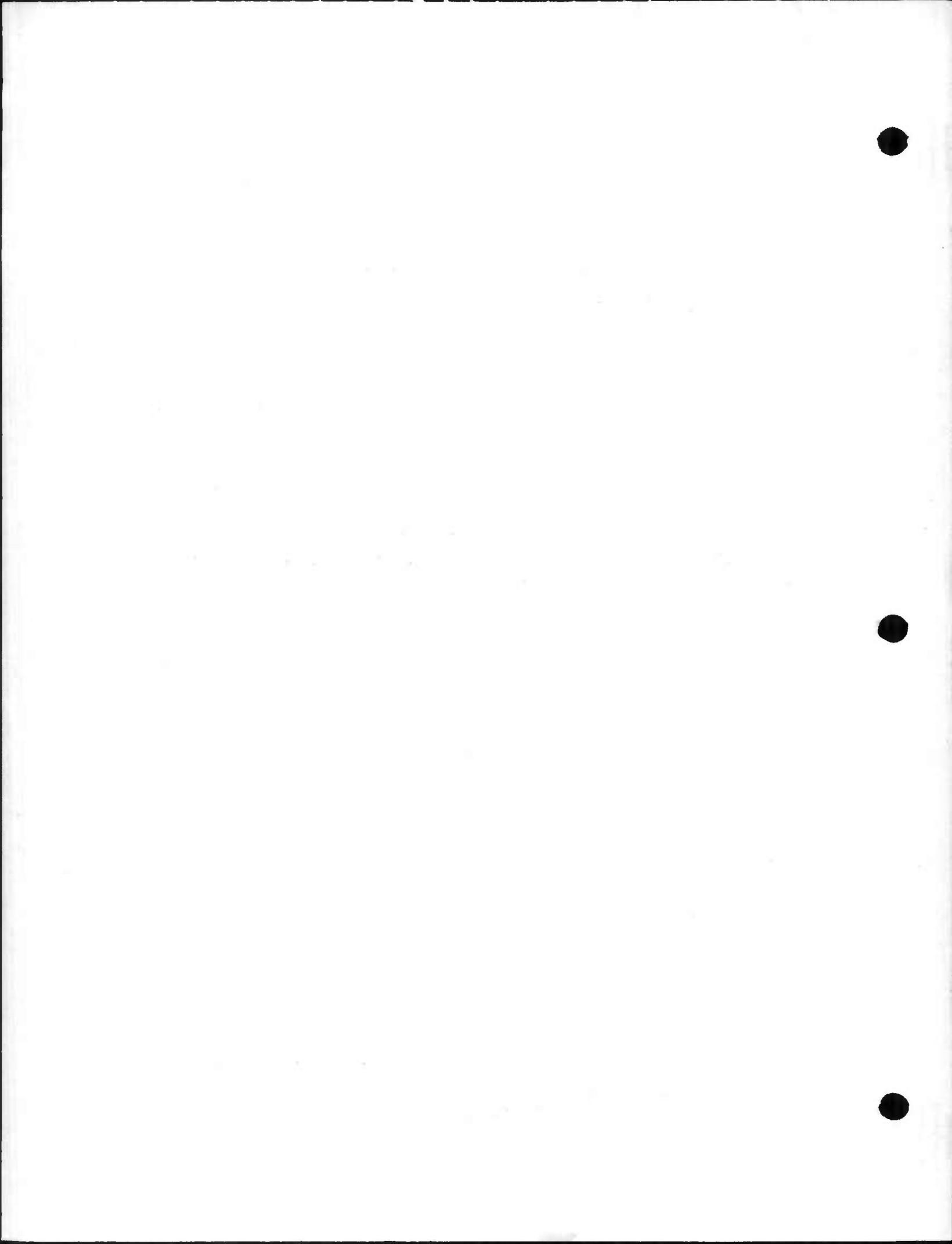


95 19258

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.													
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION													
STATE OF MARYLAND 21215-0020													
1. DECEDENT'S NAME (First, Middle, Last) SHIRLEY ANN HARRISON													
4. SOCIAL SECURITY NUMBER 218 44 9043			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2. DATE OF DEATH MONTH DAY YEAR JUNE 20, 1995		3. TIME OF DEATH 7:47 A.M.		
9a. FACILITY NAME (If not institution, give street and number) SAINT AGNES HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH N/A			7. DATE OF BIRTH (Month, Day, Year) 7/1/47			8. BIRTHPLACE (State or Foreign Country) Md.	
RESIDENCE OF DECEDENT													
10a. STATE Md.	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore City						10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2109 Harman Avenue				10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEDENT'S EDUCATION <small>(Specify only highest grade completed)</small> Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION <small>(Give kind of work done during most of working life. Do NOT use retired.)</small> homemaker						16b. KIND OF BUSINESS/INDUSTRY OWN HOME					
17. FATHER'S NAME (First, Middle, Last) Wade Harvey Palmer				18. MOTHER'S NAME (First, Middle, Maiden Surname) Oralee V. Dalton									
19a. INFORMANT'S NAME (Type/Print) Harold G. Harrison				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2109 Harman Ave. Baltimore Md. 21230									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery			DATE 6/23/95		20c. LOCATION — City or Town, State Baltimore Md. 21225						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 													
22. NAME AND ADDRESS OF FACILITY 4001 Ritchie Hwy. Baltimore Md. 21225													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Thromboemboli. <small>DUE TO (OR AS A CONSEQUENCE OF):</small>													
<small>Approximate interval Between Onset and Death</small>													
b. _____ <small>DUE TO (OR AS A CONSEQUENCE OF):</small>													
c. _____ <small>DUE TO (OR AS A CONSEQUENCE OF):</small>													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerosis cardiovascular disease													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <small>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation</small> <small>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined</small> <small>3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined</small> <small>4 <input type="checkbox"/> Homicide</small>		26a. DATE OF INJURY <small>(Month, Day, Year)</small>		26b. TIME OF INJURY <small>M</small>		26c. INJURY AT WORK? <small>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</small>		26d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <small>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</small> <small>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</small>													
29b. SIGNATURE AND TITLE OF CERTIFIER 					29c. LICENSE NUMBER O.C.M.E.			29d. DATE SIGNED (Month, Day, Year) JUNE 20, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

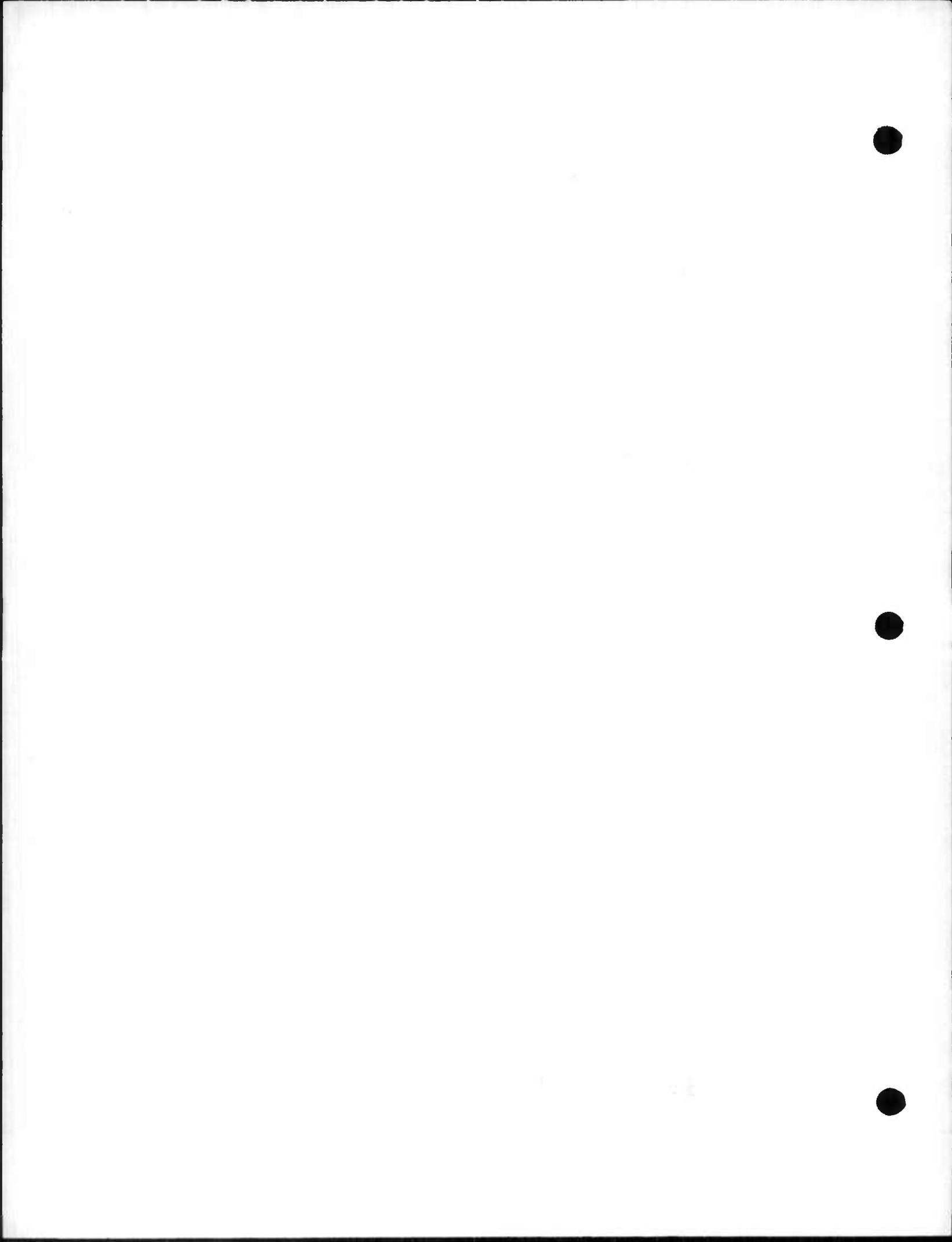
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <i>Delores C. Henson</i>											2. DATE OF DEATH MONTH DAY YEAR <i>06 23 95</i>	3. TIME OF DEATH <i>06:11 AM</i>							
4. SOCIAL SECURITY NUMBER <i>216-36-3303</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) <i>55</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>09-02-39</i>		8. BIRTHPLACE (State or Foreign Country) <i>Md</i>											
9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hospital of Baltimore</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore city</i>				9c. COUNTY OF DEATH <i>NA</i>											
RESIDENCE OF DECEDENT																			
10a. STATE <i>Md</i>	10b. COUNTY <i>NA</i>	10c. CITY, TOWN OR LOCATION <i>Baltimore</i>						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
10e. STREET AND NUMBER <i>5221 Beaufort</i>					10f. ZIP CODE <i>21215</i>			10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>											
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>Blade</i>											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>10th grade</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Dietician</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Nursing Home</i>														
17. FATHER'S NAME (First, Middle, Last) <i>Matthew Henson</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Elizabeth Ford</i>															
19a. INFORMANT'S NAME (Type/Print) <i>Melvin Beatty</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>5221 Beaufort Avenue Baltimore 21215</i>															
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) <i>MF Auburn Cen</i>			20c. DATE <i>March 1995</i>			20c. LOCATION — City or Town, State <i>Baltimore, Md</i>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glynnis B. Scott</i>											22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Avenue Baltimore 21215</i>								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>											Approximate Interval Between Onset and Death								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <table border="1"><tr><td><input type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td><input type="checkbox"/> </td></tr><tr><td><input type="checkbox"/> Suicide</td><td><input type="checkbox"/> Could not be determined</td></tr><tr><td><input type="checkbox"/> Homicide</td><td></td></tr></table>		<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident	<input type="checkbox"/>	<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED					
<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																		
<input type="checkbox"/> Accident	<input type="checkbox"/>																		
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																		
<input type="checkbox"/> Homicide																			
		28e. PLACE OF INJURY — At home, farm, street, factory, office					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald B. Scott</i>		29c. LICENSE NUMBER <i>D36353</i>			29d. DATE SIGNED (Month, Day, Year) <i>6/23/95</i>														
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>2401 W. Belvedere Avenue Sinai Hospital</i>																			
31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i>		32. REGISTRAR'S SIGNATURE <i>Susan A. Henson</i>																	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1 - FOR STATE REGISTRAR																
1. DECEASED'S NAME (First, Middle, Last) PAUL Alexander HAMPTON Sr.													2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 216-03-6071			5. SEX 1 M 2 F		6. AGE (In yrs. last birthday) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 13, 1918		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center													9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEASED																
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore City									10d. INSIDE CITY LIMITS? 1 YES 2 NO			
10e. STREET AND NUMBER 3810 Hamilton Avenue		10f. ZIP CODE 21206									10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White						14. RACE — American Indian, Black, White, etc. Specify:				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Cloth Cutter			16b. KIND OF BUSINESS/INDUSTRY Garmet										
17. FATHER'S NAME (First, Middle, Last) John Alexander Hampton						18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Lamrich										
19a. INFORMANT'S NAME (Type/Print) Ann E. Hampton			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3810 Hamilton Avenue Balto. Md. 21206			20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Cem. June 28, 1995		20c. LOCATION — City or Town, State Elkridge Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jyhey L. Gain						22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Balto. Md. 21214										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death 2 YEARS			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → END STAGE CONGESTIVE HEART FAILURE																
b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE													YEARS			
c. DUE TO (OR AS A CONSEQUENCE OF):																
d. DUE TO (OR AS A CONSEQUENCE OF):																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PNEUMONIA													24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH Natural Pending Investigation Accident 2 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED				
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													29b. SIGNATURE AND TITLE OF CERTIFIER Beatriz P. Dizon, M.D.			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEATRIZ P. DIZON, M.D.			31. DATE FILED (Month, Day, Year) JUN 26 1995			32. REGISTRATION NUMBER Juliann Rendell			33. DATE SIGNED (Month, Day, Year) June 24 1995							

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

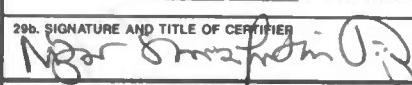
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH HOURS MIN. PM		
1. DECEDENT'S NAME (First, Middle, Last)		K. HOOPER								JUNE 22 1995 6:55 PM		
4. SOCIAL SECURITY NUMBER 216-20-4862		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct. 21, 1926		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie								9c. COUNTY OF DEATH Anne Arundel		
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 21 Sumac Road		10f. ZIP CODE 21060						10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Accounts Receiving Clerk				16b. KIND OF BUSINESS/INDUSTRY Transportation						
17. FATHER'S NAME (First, Middle, Last) George Leon Krieger		18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Viola Hood										
19e. INFORMANT'S NAME (Type/Print) Mrs. Valerie Buckland		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 313 South Carolina Ave. Pasadena, MD 21122										
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory				DATE June 23, 1995		20c. LOCATION — City or Town, State Catonsville, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Kirkley-Ruddick Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): GANGRENE OF RIGHT HAND DUE TO (OR AS A CONSEQUENCE OF): C. ANTEROSCLEROSIS RIGHT BRACHIAL ARTERY DUE TO (OR AS A CONSEQUENCE OF): d.											12 days 2 days months	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. END STAGE RENAL DISEASE											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.		29c. LICENSE NUMBER D45484		29d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MEZAR CHARAFEDINE, NORTH ARUNDEL HOSP., GLEN BURNIE, MD 21061		31. DATE FILED (Month, Day, Year) JUN 26 1995										
32. REGISTRAR'S SIGNATURE 												

1

95-3670-510

blh

95 1926

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Clarence George Hatcher												2. DATE OF DEATH MONTH DAY YEAR June 22 1995 1913	3. TIME OF DEATH M		
4. SOCIAL SECURITY NUMBER 130-14-7508			5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 10, 1925			8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) 3400 Cedardale Road												9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a	
10a. STATE Maryland		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? 1 X YES 2 F NO		10g. CITIZEN OF WHAT COUNTRY? USA					
10e. STREET AND NUMBER 3400 Cedardale Rd.					10f. ZIP CODE 21215					10h. RACE — American Indian, Black, White, etc. Specify: Black					
11. MARITAL STATUS 1 F Never Married 2 M Married 3 F Widowed 4 X Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 F NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 F YES 2 X NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Truck Driver			16b. KIND OF BUSINESS/INDUSTRY Self-Employed									
17. FATHER'S NAME (First, Middle, Last) George Hatcher					18. MOTHER'S NAME (First, Middle, Maiden Surname) Melissa Hatcher										
19a. INFORMANT'S NAME (Type/Print) Tyrone West					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1232 Cedarcroft Rd. Baltimore, Maryland 21239										
20a. METHOD OF DISPOSITION 1 X Burial 2 F Cremation 3 F Removal from State 4 F Donation 5 F Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sunny Union Bapt. Ch. Cem.					DATE June 26	20c. LOCATION — City or Town, State Cumberland Co., VA.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Leron R. Locke					22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc. 2501 Gwynns Falls Parkway Balto., MD. 21216										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Atherosclerotic Cardiovascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):												Approximate Interval Between Onset and Death			
b. _____ c. _____ d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 F NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 F NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES F NO F UNCERTAIN X															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 F NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 F Inpatient 2 F ER/Outpatient 3 F DOA 4 F Nursing Home 5 X Residence 6 F Other (Specify)												
27. MANNER OF DEATH 1 X Natural 5 F Pending Investigation 2 F Accident 6 F Could not be determined 3 F Suicide 7 F Determined 4 F Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 F YES 2 F NO		28d. DESCRIBE HOW INJURY OCCURRED					
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER 1 F CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Leron Locke MD							29c. LICENSE NUMBER O.C.M.E.			29d. DATE SIGNED (Month, Day, Year) ► June 23 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. Laron Locke M.D. 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) JUN 26 1995			32. REGISTRAR'S SIGNATURE J. Laron Locke												

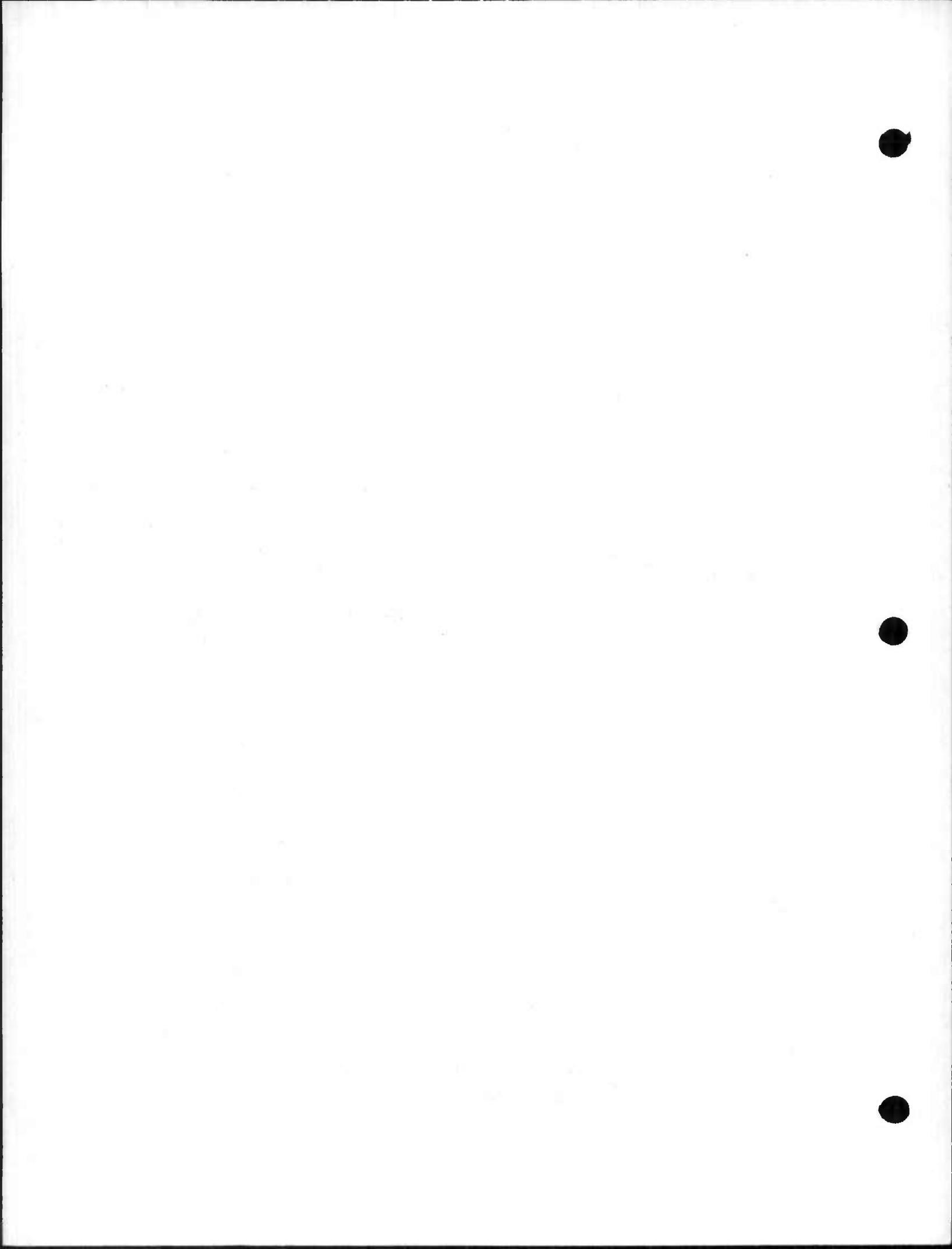
BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DIVISION OF VITAL RECORDS, P.O. BOX 687600
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		Gladys Hook						2. DATE OF DEATH		3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTH DAY YEAR		MONTH DAY YEAR	
214-34-3710		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	56 YRS.	MONTHS	DAYS	HOURS	MIN.	June 25 1995		2:30 A.M.	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Sinai Hospital				Baltimore City				Baltimore City			
RESIDENCE OF DECEDENT											
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?	
Maryland	Baltimore County			Pikesville						1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
920 Olmstead Rd.				21208				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 12 years		Homemaker				Own Home					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Harry Wilson				Annie Hoffman							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Mr. Arthur D. Hook				920 Olmstead Rd. Pikesville, MD 21208							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
		Druid Ridge Cemetery				6-28		Pikesville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John K Ayres</i>		22. NAME AND ADDRESS OF FACILITY Loring byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
		b. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):									
		c. DUE TO (OR AS A CONSEQUENCE OF):									
		d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
HOSPITAL: Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>L.Y. Chung MD</i>		29c. LICENSE NUMBER AS 2402321 KC94				29d. DATE SIGNED (Month, Day, Year) June 25, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>John Ayres</i>									

X.

1960-1961

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

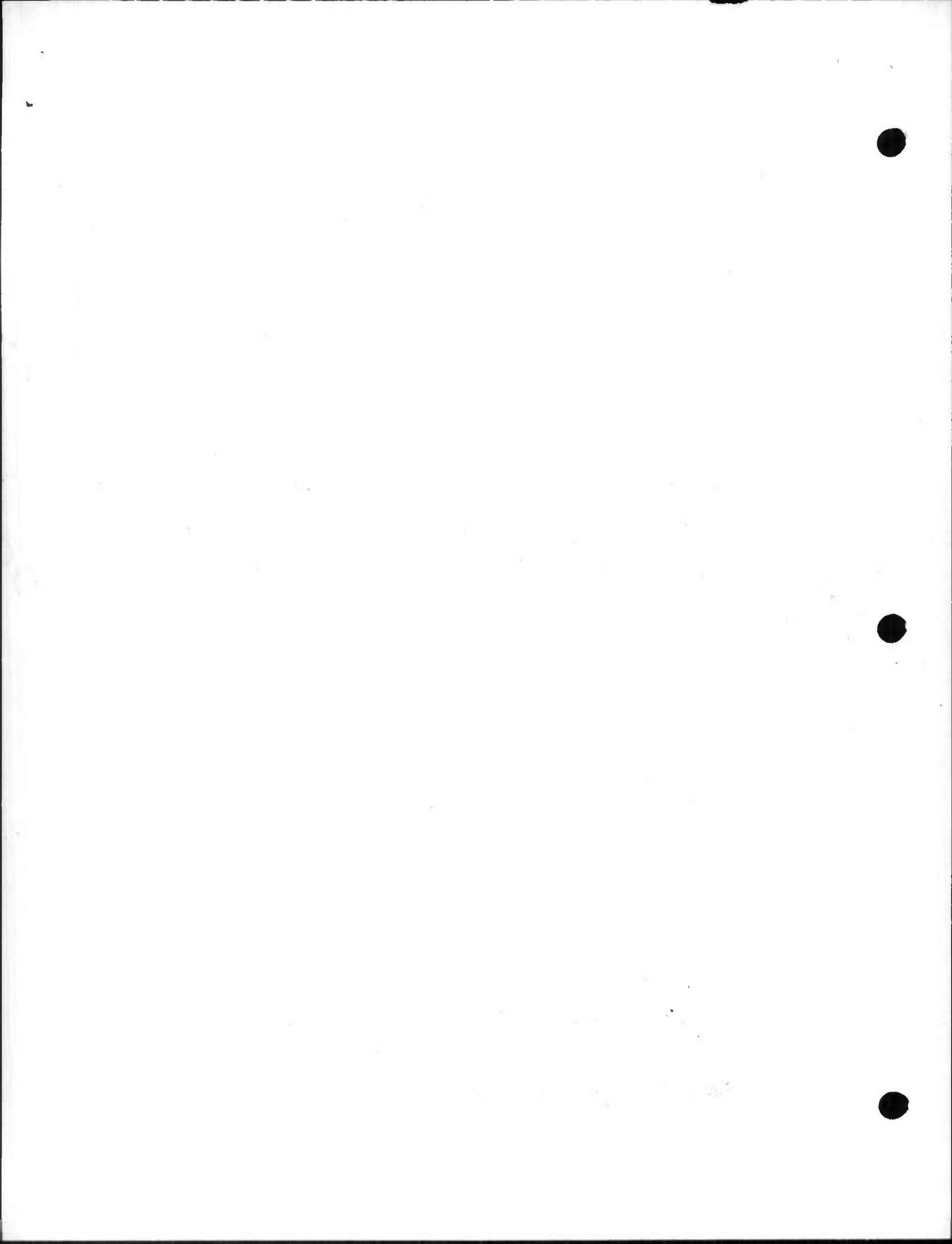
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR						3. TIME OF DEATH			
<i>Mary L. Horn</i>		JUNE 20 1995 11:49 PM									
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
217-46-2236		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	69 YRS.	MONTHS	DAYS	HOURS	MIN.	Dec. 12, 1925		Maryland	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH			
Northwest Hospital Center		Randallstown						Baltimore			
RESIDENCE OF DECEASED											
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?			
Maryland	Baltimore	Pikesville						1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
806 Templecliff Road				21208				United States			
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 12 years		Housewife				own home					
17. FATHER'S NAME (First, Middle, Last)											
Frank Pappas											
18a. INFORMANT'S NAME (Type/Print)		18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Mr. Kloman Horn		806 Templecliff Road Pikesville, MD 21208									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Woodlawn Cemetery</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place)				DATE		20c. LOCATION — City or Town, State			
		Woodlawn Cemetery				6/23		Woodlawn, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James B. Cooney</i>		22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. <i>Sepsis, Brain neoplasm</i> DUE TO (OR AS A CONSEQUENCE OF)											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
Approximate Interval Between Onset and Death											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death, but not resulting in the underlying cause given in Part I. <i>Decrease of malignant pleural effusion Neurosis i. chronic dyslipidemia</i>											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A.J. Cooper Jr. Newte.</i>		29c. LICENSE NUMBER <i>044505</i>				29d. DATE SIGNED (Month, Day, Year) <i>JUNE 20, 1995</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i>		32. REGISTRAR'S SIGNATURE <i>John W. Parker</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

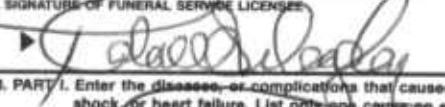
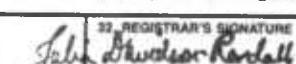
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

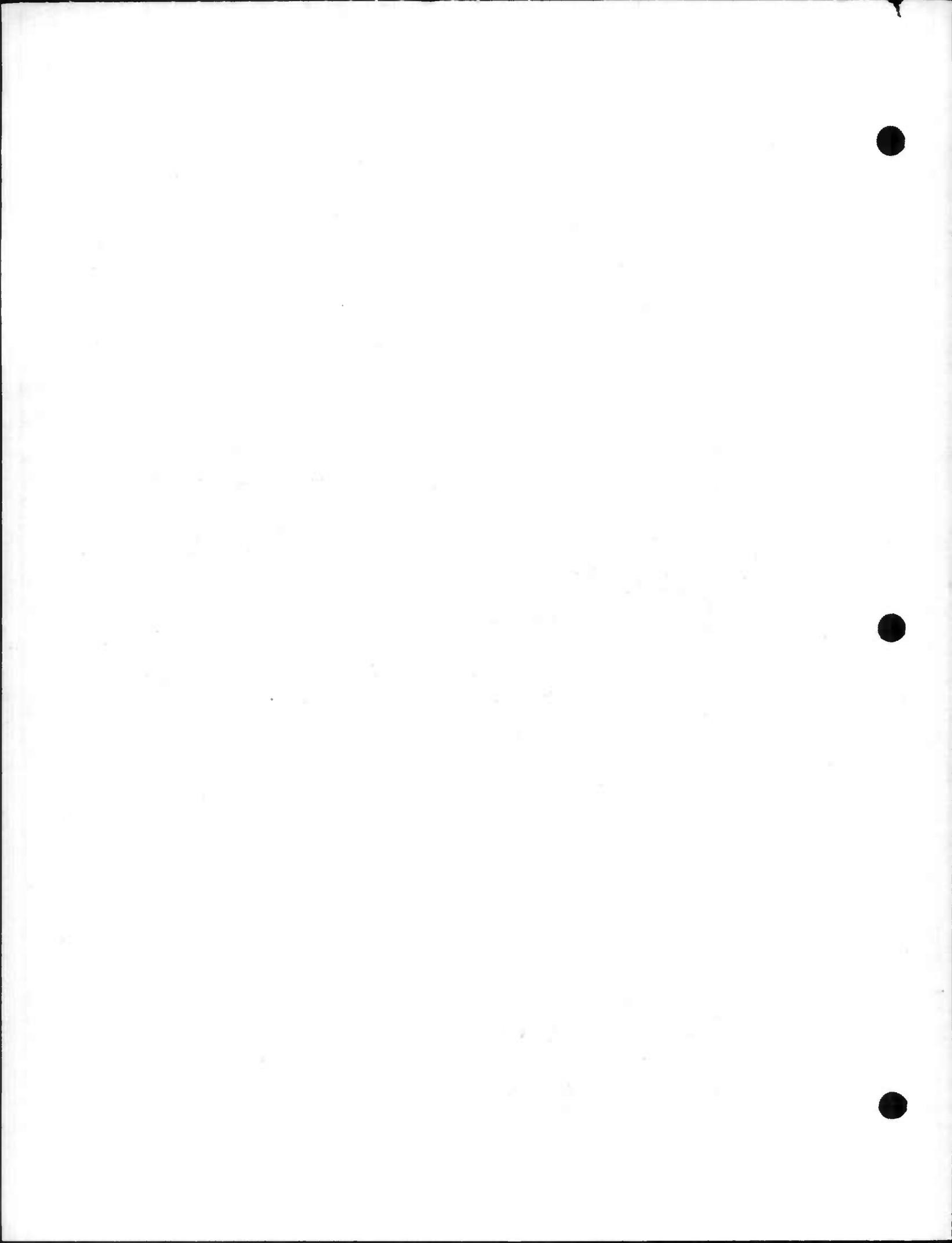
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) ARUBUTUS WALKER HOLT										2. DATE OF DEATH MONTH DAY YEAR JUNE 18, 1995	3. TIME OF DEATH 1:45 P. M
4. SOCIAL SECURITY NUMBER 218-38-9842		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) NOVEMBER 22, 1907	8. BIRTHPLACE (State or Foreign Country) WASHINGTON, DC					
9a. FACILITY NAME (If not institution, give street and number) MARYLAND MANOR OF GLEN BURNIE				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE			9c. COUNTY OF DEATH ANNE ARUNDEL				
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND	10b. COUNTY ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION GLEN BURNIE						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10a. STREET AND NUMBER 7575 EAST HOWARD ROAD				10f. ZIP CODE 21061			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: 			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Ø HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY HOME						
17. FATHER'S NAME (First, Middle, Last) ALEX MAUGANS				18. MOTHER'S NAME (First, Middle, Maiden Surname) NETTIE VIRGINIA KERN							
19a. INFORMANT'S NAME (Type/Print) WAYNE W. HOLT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6213 ROBLYNN ROAD, LAUREL, MARYLAND 20707							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ROCKCREEK CEMETERY			DATE 6/21	20c. LOCATION — City or Town, State WASHINGTON, DC			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707							
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)  Myocardial Infarction											
b. DUE TO (OR AS A CONSEQUENCE OF): Fever of Central Origin											
c. DUE TO (OR AS A CONSEQUENCE OF): Diabetes Mellitus Non - Insulin Dependent											
d. DUE TO (OR AS A CONSEQUENCE OF): Hypothyroidism											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pernicious Anemia										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
<u>Organic Brain Syndrome</u>											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 		28b. TIME OF INJURY M 	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 	28d. DESCRIBE HOW INJURY OCCURRED 					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER DT4160								29d. DATE SIGNED (Month, Day, Year) ► 06/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harjit Singh, M.D. 5410-A Ritchie Highway Baltimore, Md. 21225											
31. DATE FILED (Month, Day, Year) JUN 28 1995		32. REGISTRAR'S SIGNATURE 								DHMH-18 Rev 1/89	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

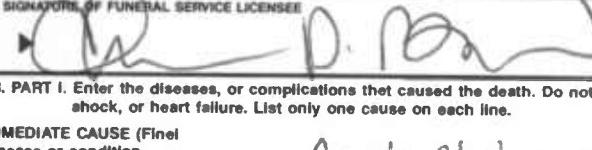
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

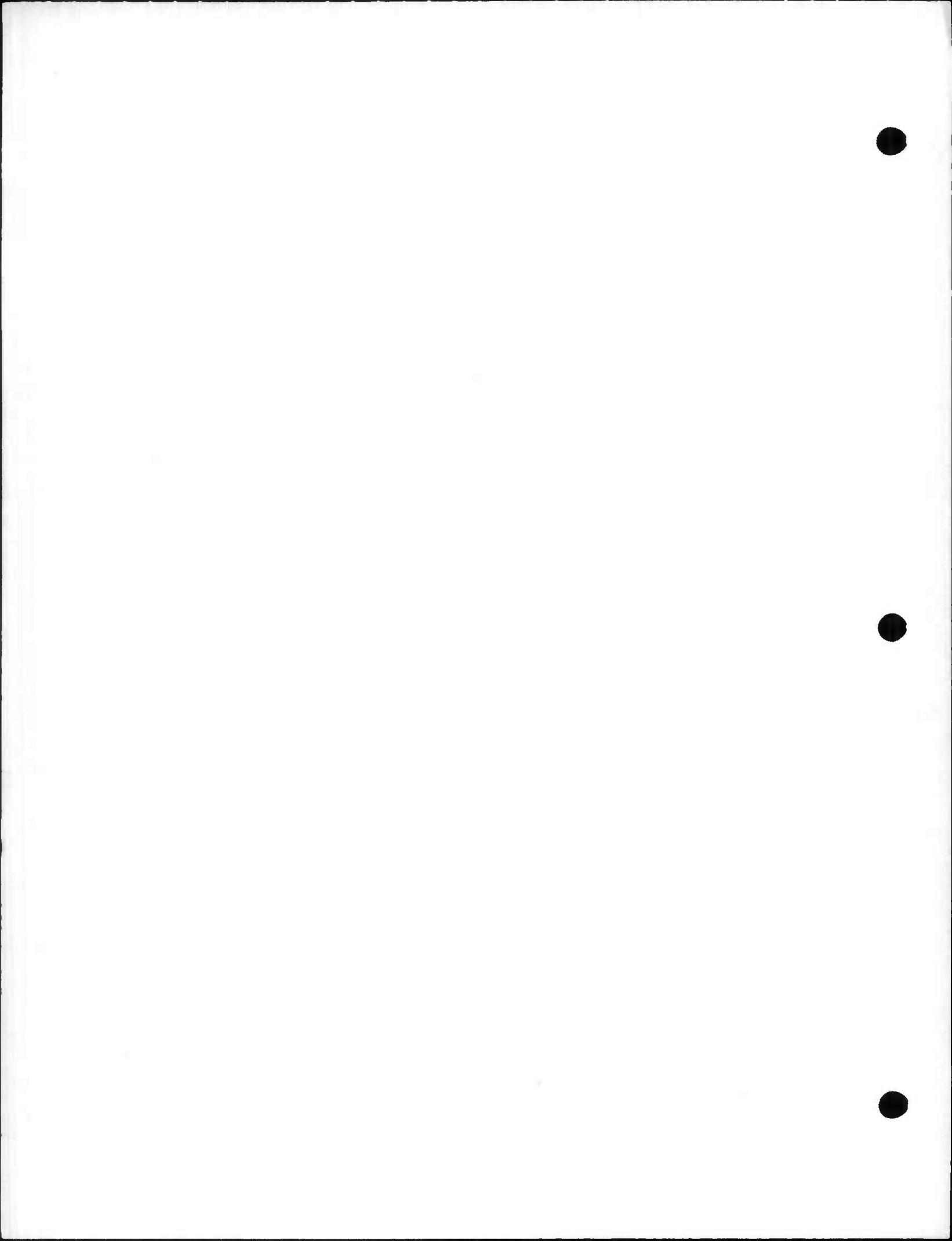
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 21 1995										3. TIME OF DEATH YEAR HOUR MIN. 10:40 P.M.			
1. DECEDENT'S NAME (First, Middle, Last) Jack Haywood												7. DATE OF BIRTH (Month, Day, Year) APRIL 16, 1912	8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA		
4. SOCIAL SECURITY NUMBER 215-05-8659		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9a. FACILITY NAME (If not institution, give street and number) LIBERTY MEDICAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		
RESIDENCE OF DECEDENT												9c. COUNTY OF DEATH N/A			
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 5129 SEKOTS ROAD, APT. A2			10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 1st GRADE		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) LABORER		16b. KIND OF BUSINESS/INDUSTRY GRAIN COMPANY		17. FATHER'S NAME (First, Middle, Last) THOMAS HAYWOOD		18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISE TENDON							
19a. INFORMANT'S NAME (Type/Print) ROSA BURGESS		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5129 SEKOTS ROAD, APT. A2, BALTIMORE, MD. 21207		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) MT. CALVARY CEMETERY		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. CALVARY CEMETERY		20c. DATE 6-26-95		20c. LOCATION — City or Town, State GLEN BURNIE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<p>a. <u>Acute Cholecystitis</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <u>Atrial Arrhythmias</u> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>										24 hrs			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												24 hrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atherosclerotic Cardiovascular Disease Abdominal Aortic Aneurysm												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26d. DESCRIBE HOW INJURY OCCURRED											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 1 1 1995		28b. TIME OF INJURY M 1		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)													
29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D.		29c. LICENSE NUMBER 041365		29d. DATE SIGNED (Month, Day, Year) ► June 21, 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. 2600 Liberty Heights Ave, 21216												31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRATION NUMBER John J. Wicks	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

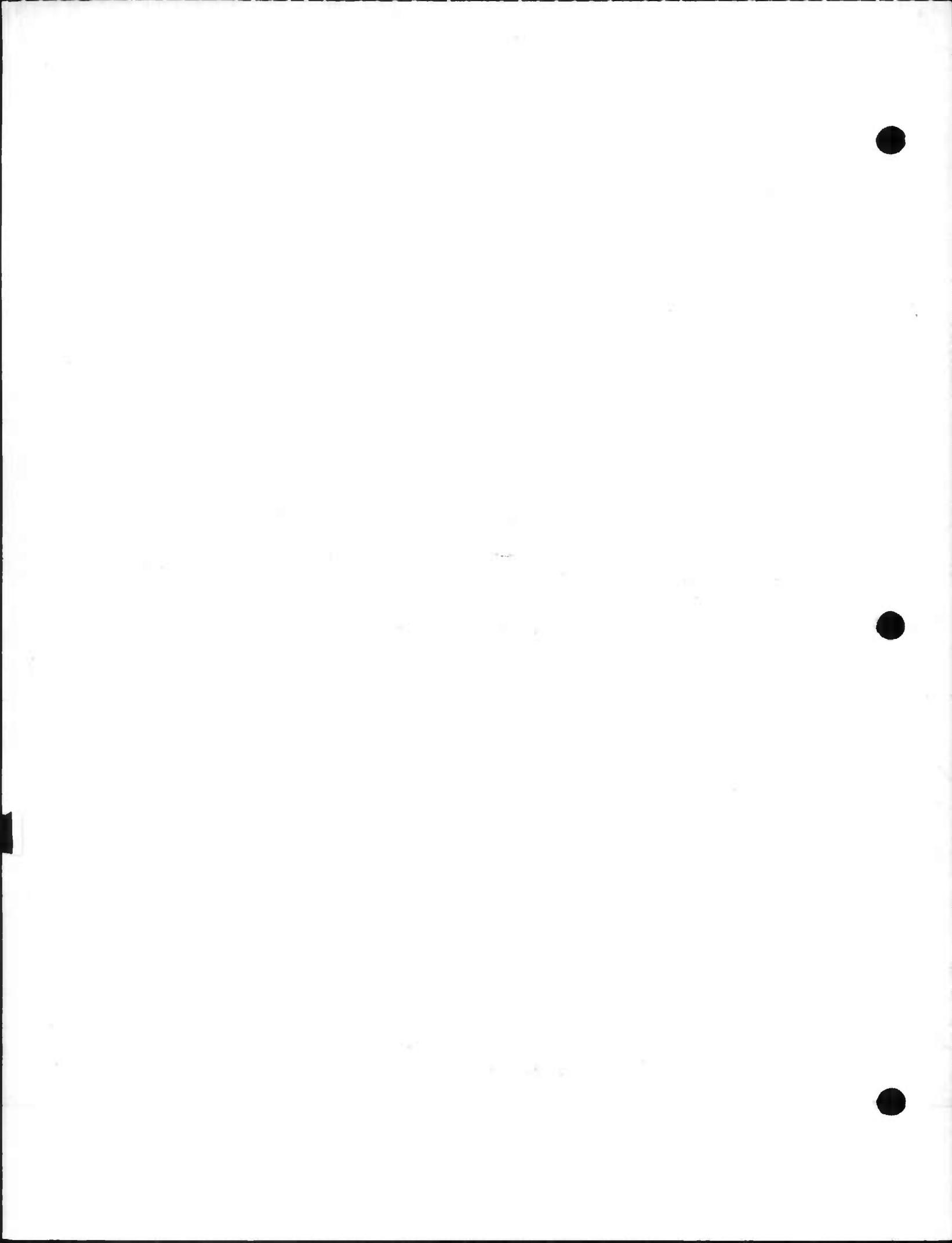
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 21 1995								3. TIME OF DEATH 1230 M	
1. DECEDENT'S NAME (First, Middle, Last) DANA RENEE JOHNSON										7. DATE OF BIRTH (Month, Day, Year) July 10, 1972	
4. SOCIAL SECURITY NUMBER 263-91-5378		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 22 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Florida			
9a. FACILITY NAME (If not institution, give street and number) Deaton Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore								9c. COUNTY OF DEATH NA	
10a. STATE Md		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1216 W. Lafayette Avenue				10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U.S.A			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) NA Unemployed				16b. KIND OF BUSINESS/INDUSTRY NA					
17. FATHER'S NAME (First, Middle, Last) Clifford Johnson		16. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Colter									
18a. INFORMANT'S NAME (Type/Print) Elizabeth Johnson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1216 W. Lafayette Avenue Baltimore 21217									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park 06/03/95				DATE 06/03/95		20c. LOCATION — City or Town, State Randallstown, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Syle March		22. NAME AND ADDRESS OF FACILITY Mayfield F. W. West 4360 Walbach Ave Baltimore 21215									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. DIABETES INSIPIDUS DUE TO (OR AS A CONSEQUENCE OF): CRANIOPHARYNGIOMA DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										1987 1987	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PANHYPOPITUITARISM, ORGANIC ENCEPHALOPATHY										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be 4 <input type="checkbox"/> Homicide determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D31136								29d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BRIAN C. WALLACE MD, 611 S. CHARLES ST., BALTIMORE, MD 21230											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. SIGNATURE [Signature]									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

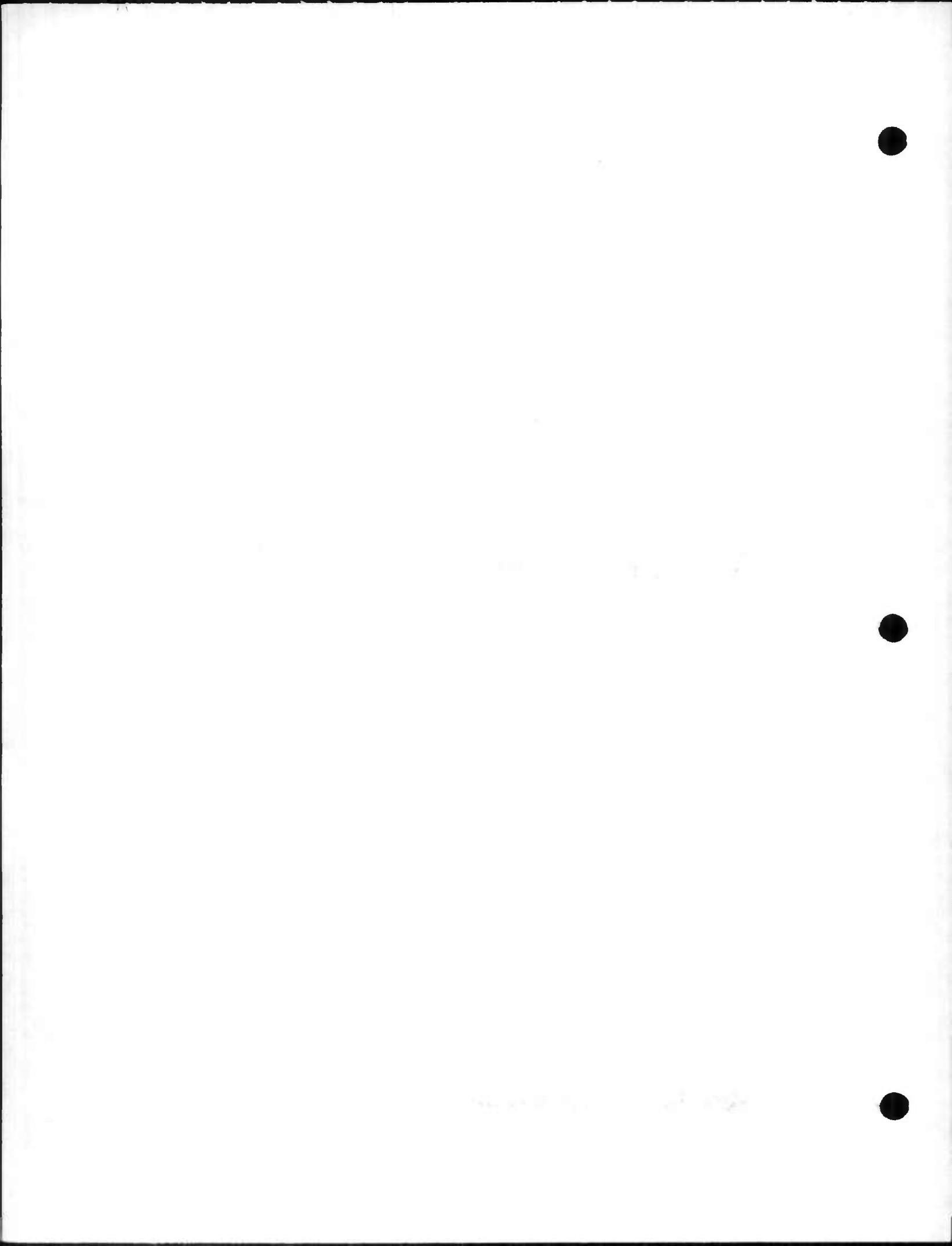
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
CHARLES O. JACKSON											JUNE 24 1995	7:00 A.M.		
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct 18, 1900		8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital											9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH n/a	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville		10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 26 Winters Lane											10i. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade School.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Guard		16b. KIND OF BUSINESS/INDUSTRY Baltimore County Schools										
17. FATHER'S NAME (First, Middle, Last) George Jackson											18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Dorsey			
19a. INFORMANT'S NAME (Type/Print) John Jackson		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5426 Lewellen Avenue Baltimore, Maryland 21207												
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bushy Park Cemetery		20c. DATE — City or Town, State June 28 Howard County, MD										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Herbert E. Nutter											22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF):														
b. URINARY TRACT INFECTION DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE, Electrolytes Imbalance Coronary artery Disease											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)											28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 46704		29d. DATE SIGNED (Month, Day, Year) ► June 24, 1995										
29e. SIGNATURE AND TITLE OF CERTIFIER Automo Mankonde, MD														
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Automo MANKONDE, ST AGNES HOSPITAL														
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE John St. John, Registrar												



DIVISION OF VITAL RECORDS, P.O. BOX 68760

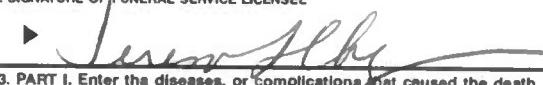
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

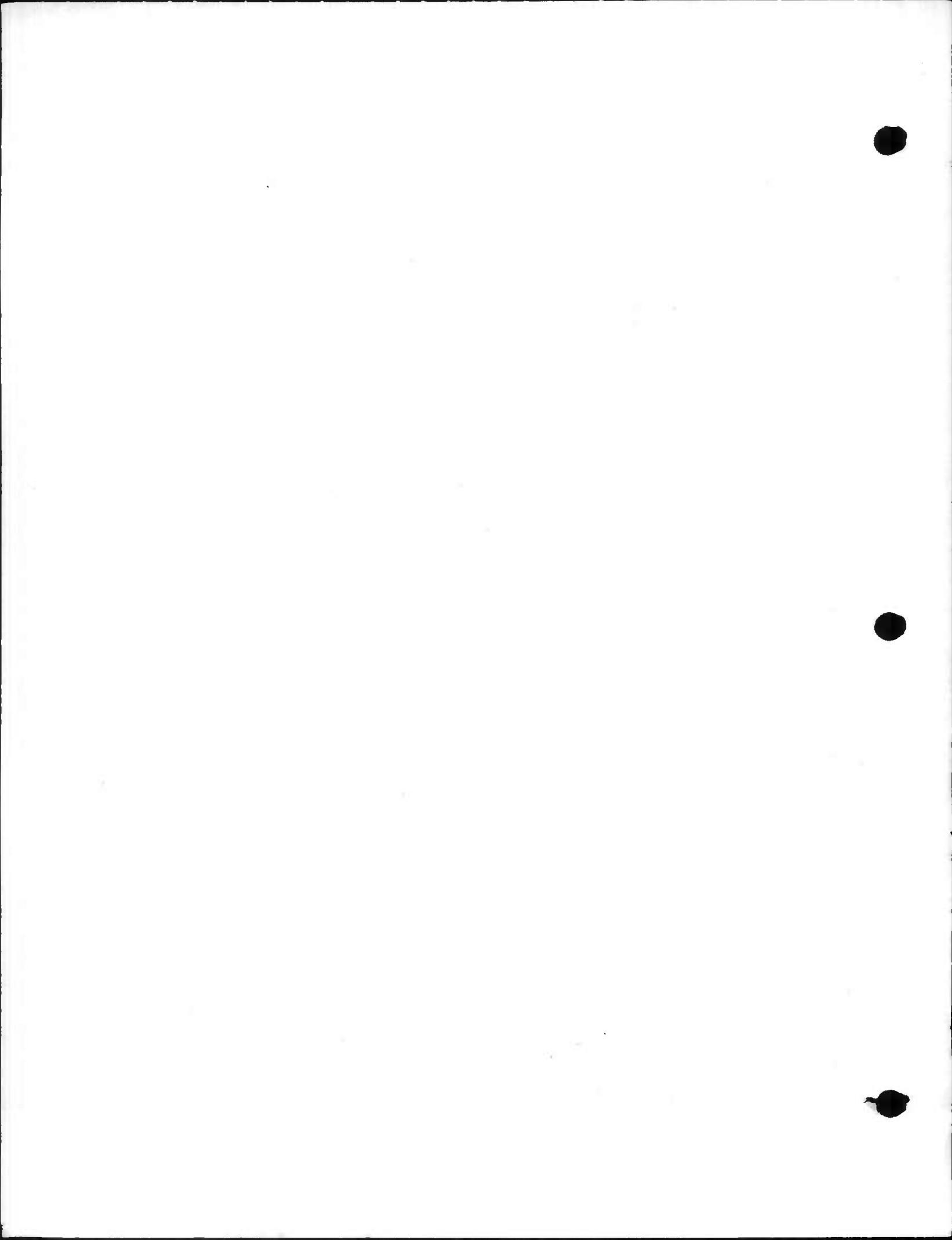
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) RONALD JACKSON											2. DATE OF DEATH MONTH 6 DAY 21 YEAR 85	3. TIME OF DEATH 12:30 A.M.
4. SOCIAL SECURITY NUMBER 220-68-3109		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) MAR. 24, 1957		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 825 Payson St.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A				
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 X YES 2 NO				
10e. STREET AND NUMBER 825 N. Payson Street				10f. ZIP CODE 21217				10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO		14. RACE — American Indian, Black, White, etc. Specify: Black						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cook		16b. KIND OF BUSINESS/INDUSTRY Hospital								
17. FATHER'S NAME (First, Middle, Last) John Jackson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Jones								
19a. INFORMANT'S NAME (Type/Print) Ida Ghee				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 841 N. Milton Ave./Baltimore, MD 21205								
20a. METHOD OF DISPOSITION 1 □ Burial 2 X Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Cemetery		DATE 6/26	20c. LOCATION — City or Town, State Baltimore, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY March F.H. East 1101 E. North Ave.								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Disease Cytomegalovirus Infection DUE TO (OR AS A CONSEQUENCE OF):										2 months		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. Acquired Immuno Deficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF):										> 5 years		
c. DUE TO (OR AS A CONSEQUENCE OF): d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Tuberculosis Encephalitis; Mycobacterium Avium Complex Sepsis										24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)										
27. MANNER OF DEATH 1 □ Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Robert Kent, M.D.		29c. LICENSE NUMBER P06966				29d. DATE SIGNED (Month, Day, Year) 6/21/85						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert Kent, M.D. 1001 N Cathedral St., Balt 21201												
31. DATE FILED (Month, Day, Year) 6/21/85 JUN 26 1995		32. REGISTRAR'S SIGNATURE John Michael Randall										



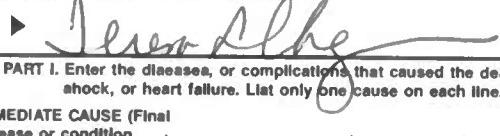
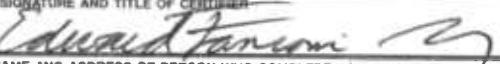
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

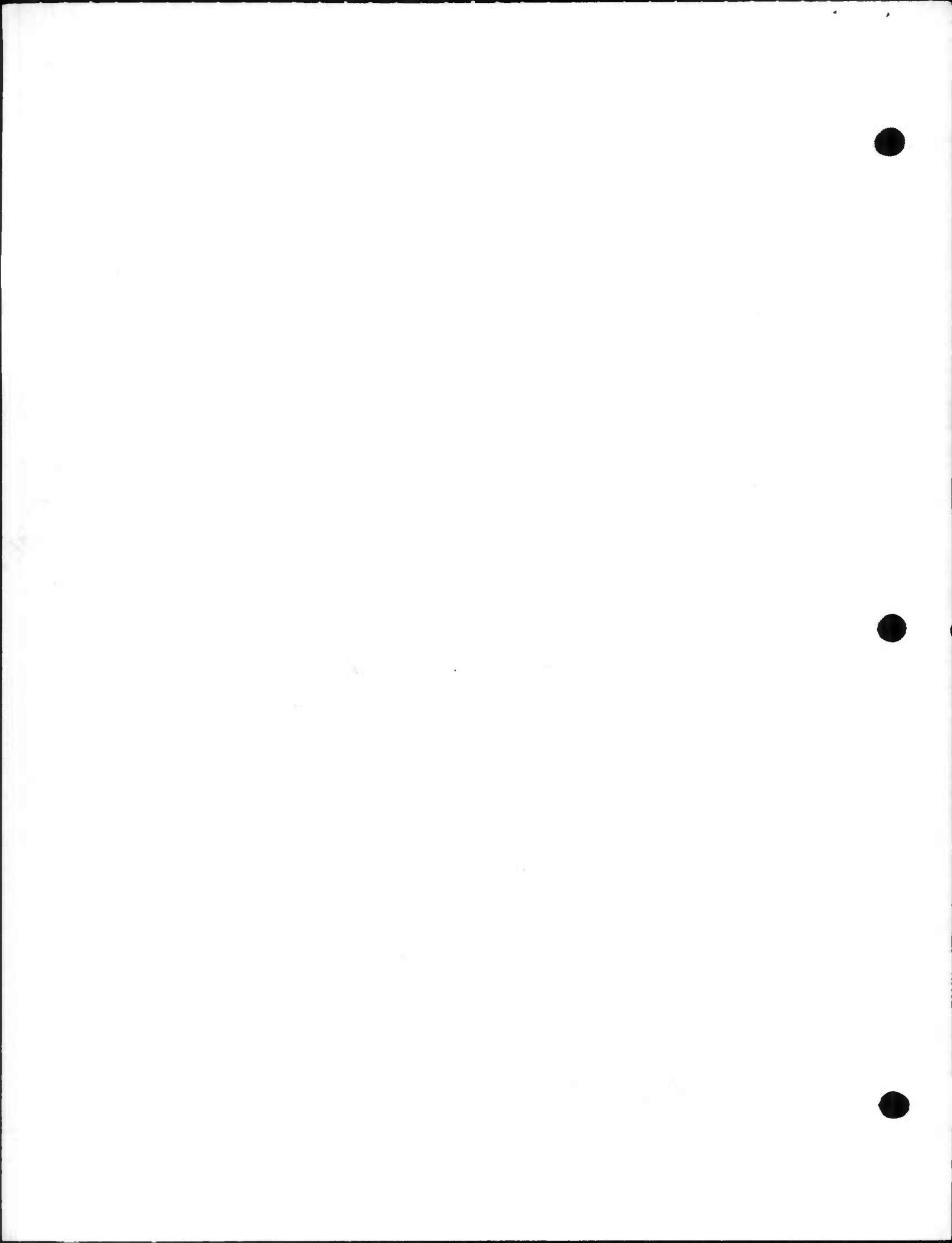
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) WALLACE GEORGE JONES, JR.											2. DATE OF DEATH MONTH DAY YEAR June 22, 1995	3. TIME OF DEATH 6:10 A.M.
4. SOCIAL SECURITY NUMBER 218-28-8490		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 60 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) FEB. 1, 1935		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 2447 E. Eager Street											9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	9c. COUNTY OF DEATH N/A
RESIDENCE OF DECEDENT												
10a. STATE MD	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 2447 E. Eager Street										10f. ZIP CODE 21205	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Factory Worker				16b. KIND OF BUSINESS/INDUSTRY Bethlehem Steel						
17. FATHER'S NAME (First, Middle, Last) Wallace Jones, Sr.										18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Turner		
19a. INFORMANT'S NAME (Type/Print) Sarah Jones					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2447 E. Eager Street/Baltimore, MD 21205							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park				DATE 6/28	20c. LOCATION — City or Town, State Randallstown, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY March Funeral Home East 1101 E. North Ave./Baltimore, MD 21202							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. presumed cardiac arrhythmia DUE TO (OR AS A CONSEQUENCE OF):												
b. dilated cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF):												
c. hypertension and diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF):												
d.												
Approximate Interval Between Onset and Death immediate												
8 yrs												
30+ yrs												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. renal insufficiency, chronic anemia												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one)												
HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
2 <input type="checkbox"/> Accident		3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
4 <input type="checkbox"/> Homicide												
29a. CERTIFIER (Check only one)		1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
30. SIGNATURE AND TITLE OF CERTIFIER 		31. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		32. LICENSE NUMBER D 41997		33. DATE OF DEATH (Month, Day, Year)		34. DATE SIGNED (Month, Day, Year)				
Edward Fancovic MD, 1005 North Point Blvd., Baltimore, MD 21224		JUN 26 1995 John Wallace Jones				6/26/95						
35. DEATH CERTIFICATE SIGNATURE												



95 19271

1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME Douglas RAYMOND PAUL JAROSINSKI												2. DATE OF DEATH MONTH JUNE DAY 20, 1995 YEAR	3. TIME OF DEATH 09:17 A.M.
4. SOCIAL SECURITY NUMBER 213-50-9841		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Mar. 6, 1951	8. BIRTHPLACE (State or Foreign Country) MARYLAND						
9a. FACILITY NAME (If not institution, give street and number) BENFIELD BLVD.				9b. CITY, TOWN OR LOCATION OF DEATH UNKNOWN BY INFORMANT			9c. COUNTY OF DEATH ANNE ARUNDEL						
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 X NO	
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION PASADENA			10f. ZIP CODE 21122			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 X NO IF YES, GIVE WAR OR DATES 12 1 Contractor Owner/President			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc.					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 1 Contractor Owner/President			16b. KIND OF BUSINESS/INDUSTRY Construction								
17. FATHER'S NAME (First, Middle, Last) Gerard Joseph Jarosinski						18. MOTHER'S NAME (First, Middle, Maiden Surname) Patricia Mary Frentz							
19a. INFORMANT'S NAME (Type/Print) Mrs. Douglas P. Jarosinski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 115 Hastings Lane, Pasadena, MD 21122									
20a. METHOD OF DISPOSITION 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens			DATE JUNE 24		20c. LOCATION — City or Town, State Timonium, MD 21093				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lowell M. Lemmon				22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home of Dulaney Valley, Inc. 10 W. Padonia Rd., Timonium, MD 21093									
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. HEAD INJURIES DUE TO (OR AS A CONSEQUENCE OF):												Approximate Interval Between Onset and Death	
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____												24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) PODNEY										INVOLVED IN MVA	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 X Accident 6 <input type="checkbox"/> Collision 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Ejected 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 6 20 95			28b. TIME OF INJURY 0905 AM	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURRED Driven off car, collision, ejected						
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) PODNEY		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) BENFIELD BLVD. ANN ARUNDEL 21093											
29a. CERTIFIER 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29d. DATE SIGNED (Month, Day, Year) JUNE 21, 1995	
29b. SIGNATURE AND TITLE OF CERTIFIER John Johnson-Hardell												29c. LICENSE NUMBER OCME	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MD MARYLAND D. L. Johnson 111 Penn Street, Baltimore, Maryland 21201												31. DATE FILED (Month, Day, Year) JUN 26 1995	
32. REGISTRAR'S SIGNATURE John Johnson-Hardell													

BALTIMORE, MARYLAND 21215-0020

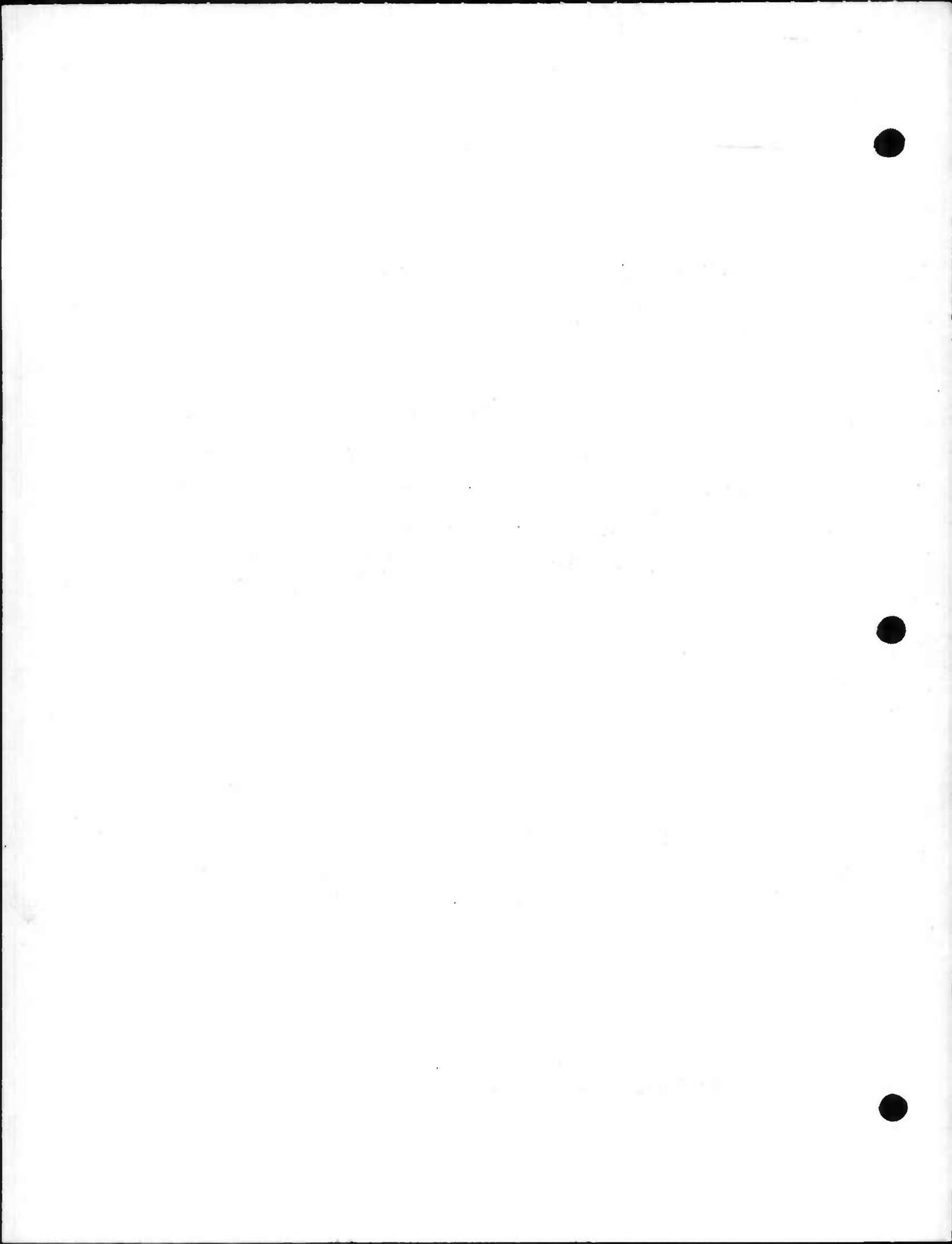
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

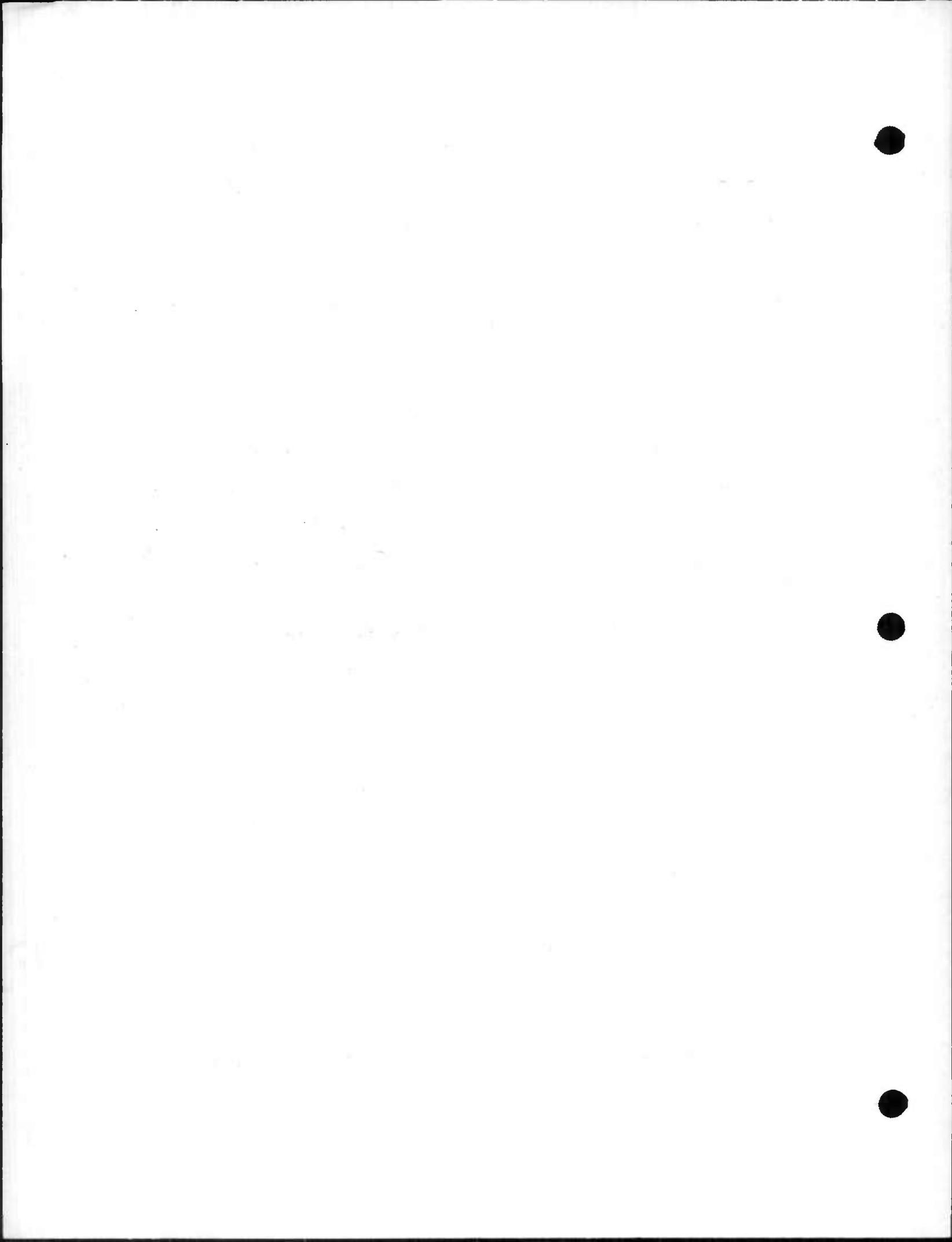
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		Robert Leon Kelch						2. DATE OF DEATH MONTH JUNE DAY 21 YEAR 1995		3. TIME OF DEATH 0702 M	
4. SOCIAL SECURITY NUMBER 212-30-6485		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) March 6, 1933		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 6514 Brown Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore						9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEDENT 10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6514 Brown Avenue		10f. ZIP CODE 21224						10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Desk Clerk		16b. KIND OF BUSINESS/INDUSTRY Broadcasting							
17. FATHER'S NAME (First, Middle, Last) William Henry Kelch		18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose A. Kulwicki									
19a. INFORMANT'S NAME (Type/Print) Catherine Sommers		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1628 Manor Road Baltimore, Maryland 21222									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp. 6/22/95						20c. LOCATION — City or Town, State Towson, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Johnny L. Gibb		22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Avenue Baltimore, Maryland 21222									
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IMPERFECT	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Margarita Korell M.D.		29c. LICENSE NUMBER O.C.M.E.						29d. DATE SIGNED (Month, Day, Year) June 21 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Margarita Korell M.D.		111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Julia [Signature]									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

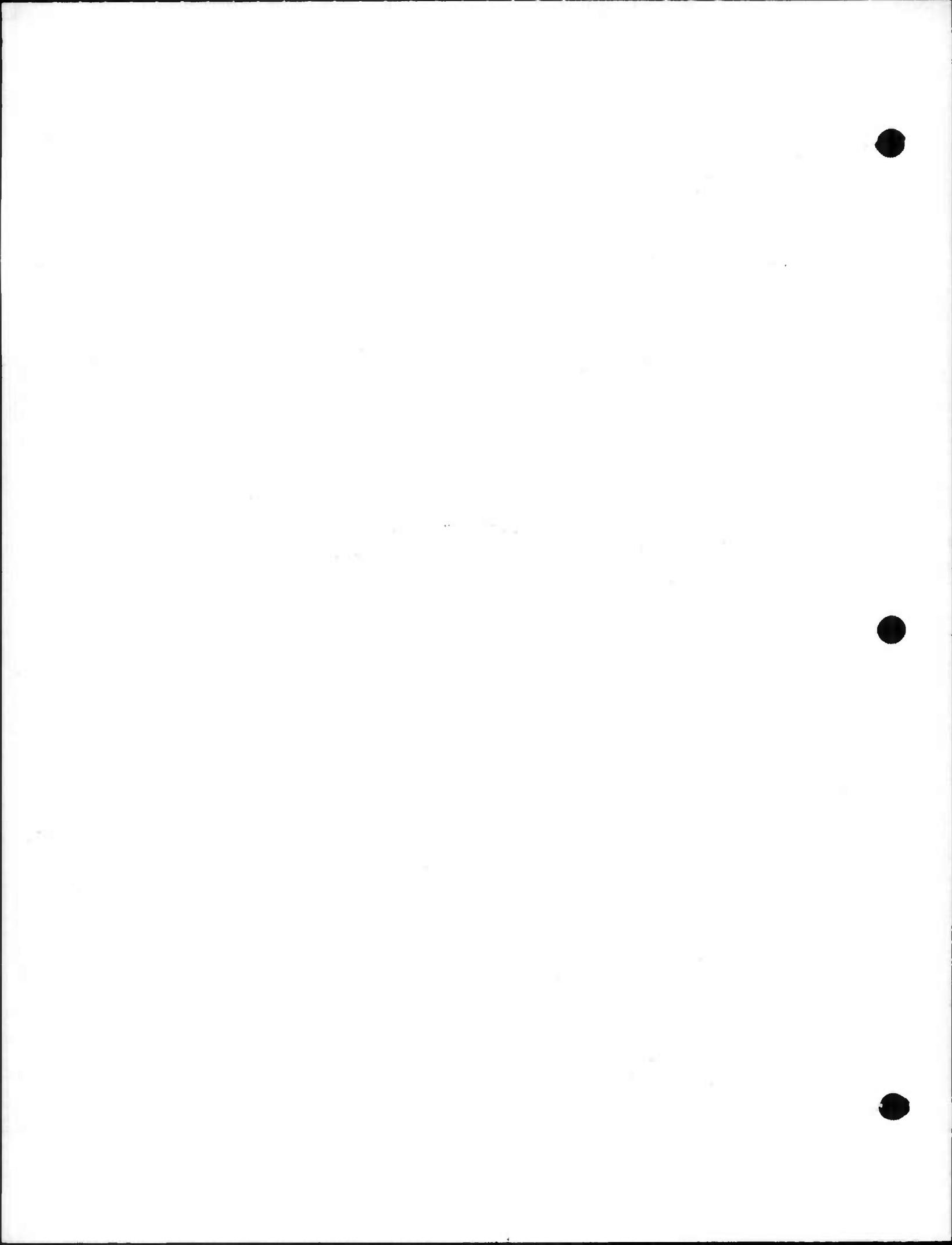
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) Maria R. Katsaros 4. SOCIAL SECURITY NUMBER 219-12-5343 5. SEX <1 <input type="checkbox"/> M <2 <input checked="" type="checkbox"/> F 6. AGE (In yrs. last birthday) 94 YRS. 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 8. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1900 9. FACILITY NAME (If not institution, give street and number) Manor Care Ruxton RESIDENCE OF DECEASED 10a. STATE Maryland 10b. COUNTY Baltimore 10c. CITY, TOWN OR LOCATION Towson 10d. INSIDE CITY LIMITS? <1 <input type="checkbox"/> YES <2 <input checked="" type="checkbox"/> NO							2. DATE OF DEATH MONTH DAY YEAR 6-21-95		3. TIME OF DEATH 9 30 P.M.	
9b. CITY, TOWN OR LOCATION OF DEATH Towson 9c. COUNTY OF DEATH Baltimore							7. DATE OF BIRTH (Month, Day, Year) Aug. 15, 1900 8. BIRTHPLACE (State or Foreign Country) Greece			
10e. STREET AND NUMBER 305 E. Joppa Rd. Tabco Towers 10f. ZIP CODE 21204							10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <1 <input type="checkbox"/> Never Married <2 <input type="checkbox"/> Married <3 <input type="checkbox"/> Widowed <4 <input type="checkbox"/> Divorced X		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <1 <input type="checkbox"/> YES <2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <1 <input type="checkbox"/> YES <2 <input checked="" type="checkbox"/> NO Specify: X			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home						
17. FATHER'S NAME (First, Middle, Last) William Routsis							18. MOTHER'S NAME (First, Middle, Maiden Surname) Aspasia (unknown)			
19a. INFORMANT'S NAME (Type/Print) Mr. George Kokinos							19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 334 Presway Rd., Timonium, Md. 21093			
20a. METHOD OF DISPOSITION <1 <input type="checkbox"/> Burial <2 <input type="checkbox"/> Cremation <3 <input type="checkbox"/> Removal from State <4 <input type="checkbox"/> Donation <5 <input type="checkbox"/> Other (Specify) X		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greek Orthodox		DATE 6-24-95		20c. LOCATION — City or Town, State Baltimore, Md.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ernest L. Feist, III							22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → A. Acute Stroke. DUE TO (OR AS A CONSEQUENCE OF): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of):							Approximate Interval Between Onset and Death 1 day			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 							24a. WAS AN AUTOPSY PERFORMED? <1 <input type="checkbox"/> YES <2 <input checked="" type="checkbox"/> NO X			
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <1 <input type="checkbox"/> YES <2 <input type="checkbox"/> NO 1			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							24c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <1 <input type="checkbox"/> YES <2 <input type="checkbox"/> NO 1			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <1 <input type="checkbox"/> YES <2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <1 <input type="checkbox"/> Inpatient <2 <input type="checkbox"/> ER/Outpatient <3 <input type="checkbox"/> DOA <4 <input type="checkbox"/> Nursing Home <5 <input type="checkbox"/> Residence <6 <input type="checkbox"/> Other (Specify)		OTHER: <1 <input type="checkbox"/> Inpatient <2 <input type="checkbox"/> ER/Outpatient <3 <input type="checkbox"/> DOA <4 <input type="checkbox"/> Nursing Home <5 <input type="checkbox"/> Residence <6 <input type="checkbox"/> Other (Specify)		28d. DESCRIBE HOW INJURY OCCURRED				
27. MANNER OF DEATH <1 <input checked="" type="checkbox"/> Natural <5 <input type="checkbox"/> Pending Investigation <2 <input type="checkbox"/> Accident <6 <input type="checkbox"/> Determined <3 <input type="checkbox"/> Suicide <7 <input type="checkbox"/> Could not be determined <4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year) 		28b. TIME OF INJURY M 1		28c. INJURY AT WORK? <1 <input type="checkbox"/> YES <2 <input checked="" type="checkbox"/> NO 1		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office Building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 		
29a. CERTIFIER (Check only one) <1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year) ► 6-22-95		
29b. SIGNATURE AND TITLE OF CERTIFIER A. H. Ghiladi, M.D.							29c. LICENSE NUMBER D-12849			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. H. Ghiladi, M.D. 7600 Osler Drive, Suite 111, Towson, Md. 21204										
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Juliann Rattell								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

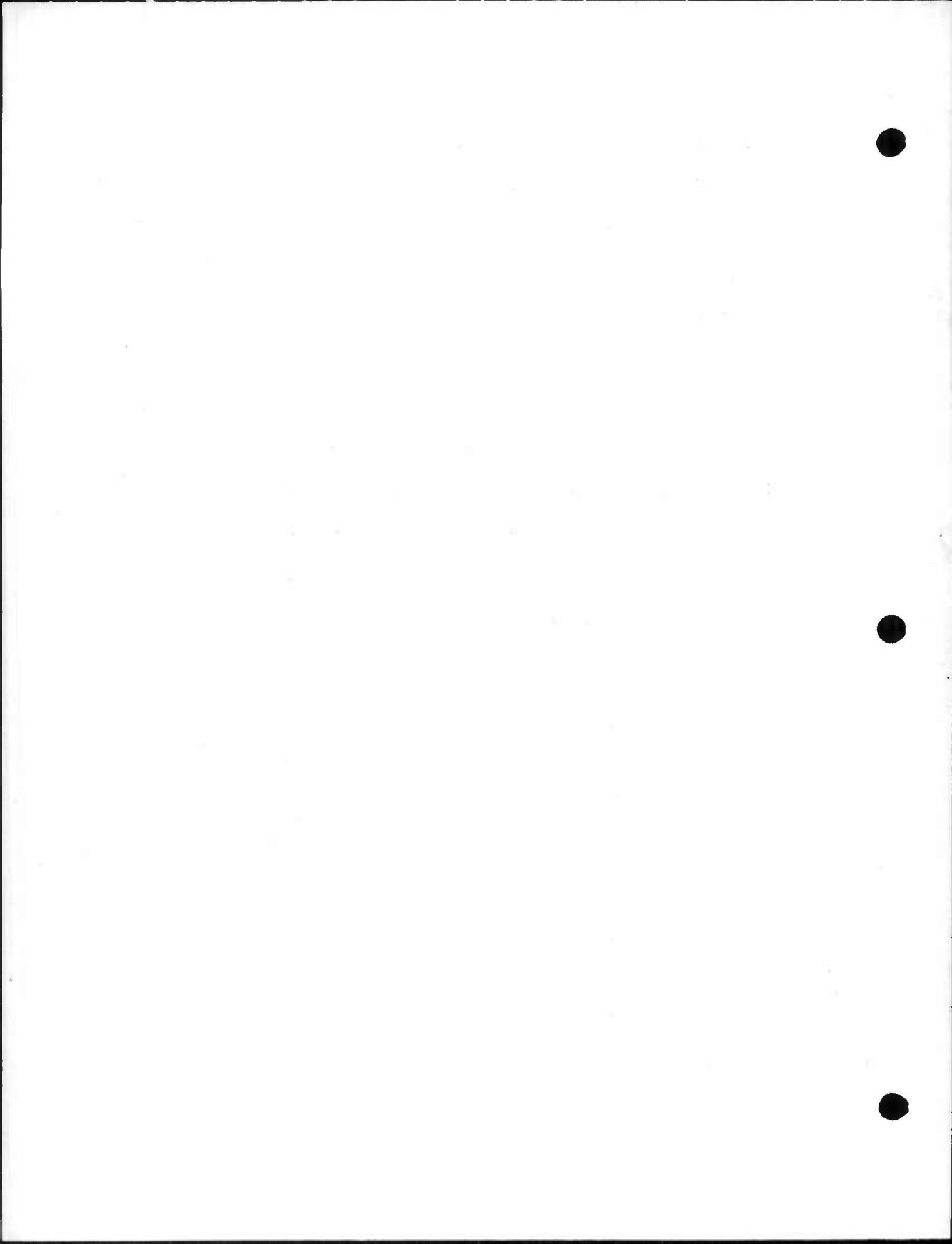
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) CATHERINE ANNA KUHNS												2. DATE OF DEATH MONTH DAY YEAR June 22 1995		3. TIME OF DEATH 4:00 AM	
4. SOCIAL SECURITY NUMBER 216-14-4324		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 MONTHS 0 DAYS 0 HOURS 0 MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 28, 1921		8. BIRTHPLACE (State or Foreign Country) Md.					
9a. FACILITY NAME (If not institution, give street and number) Dulaney Towson Nursing Home												9b. CITY, TOWN OR LOCATION OF DEATH Towson		9c. COUNTY OF DEATH Baltimore	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Phoenix				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 3805 Duddington Way						10f. ZIP CODE 21131		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary		16b. KIND OF BUSINESS/INDUSTRY Bendix Corp.											
17. FATHER'S NAME (First, Middle, Last) Robert		18. MOTHER'S NAME (First, Middle, Maiden Surname) Fanning		19. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie				20. MOTHER'S NAME (First, Middle, Maiden Surname) Freter							
19e. INFORMANT'S NAME (Type/Print) Mr. Gregory T. Moss, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3805 Duddington Way Phoenix, Md. 21131													
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp.		DATE 6/24/95		20c. LOCATION — City or Town, State Towson, Md.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Atherosclerotic Vascular Disease</i>															
s. DUE TO (OR AS A CONSEQUENCE OF): <i>h/o Stroke, h/o VRO Sepsis</i>															
b. DUE TO (OR AS A CONSEQUENCE OF): <i></i>															
c. DUE TO (OR AS A CONSEQUENCE OF): <i></i>															
d. DUE TO (OR AS A CONSEQUENCE OF): <i></i>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i></i>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)				OTHER: 									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i></i>									
		28c. INJURY AT WORK? 				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. LICENSE NUMBER D21Y6F		29d. DATE SIGNED (Month, Day, Year) ► 6/23/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert T. Liberto, M.D., 3805 Bank St. Baltimore, Md.															
31. DATE FILED (Month, Day, Year) JUN 26 1995															



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

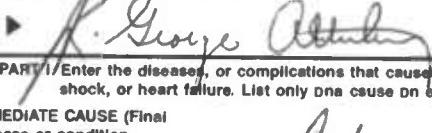
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

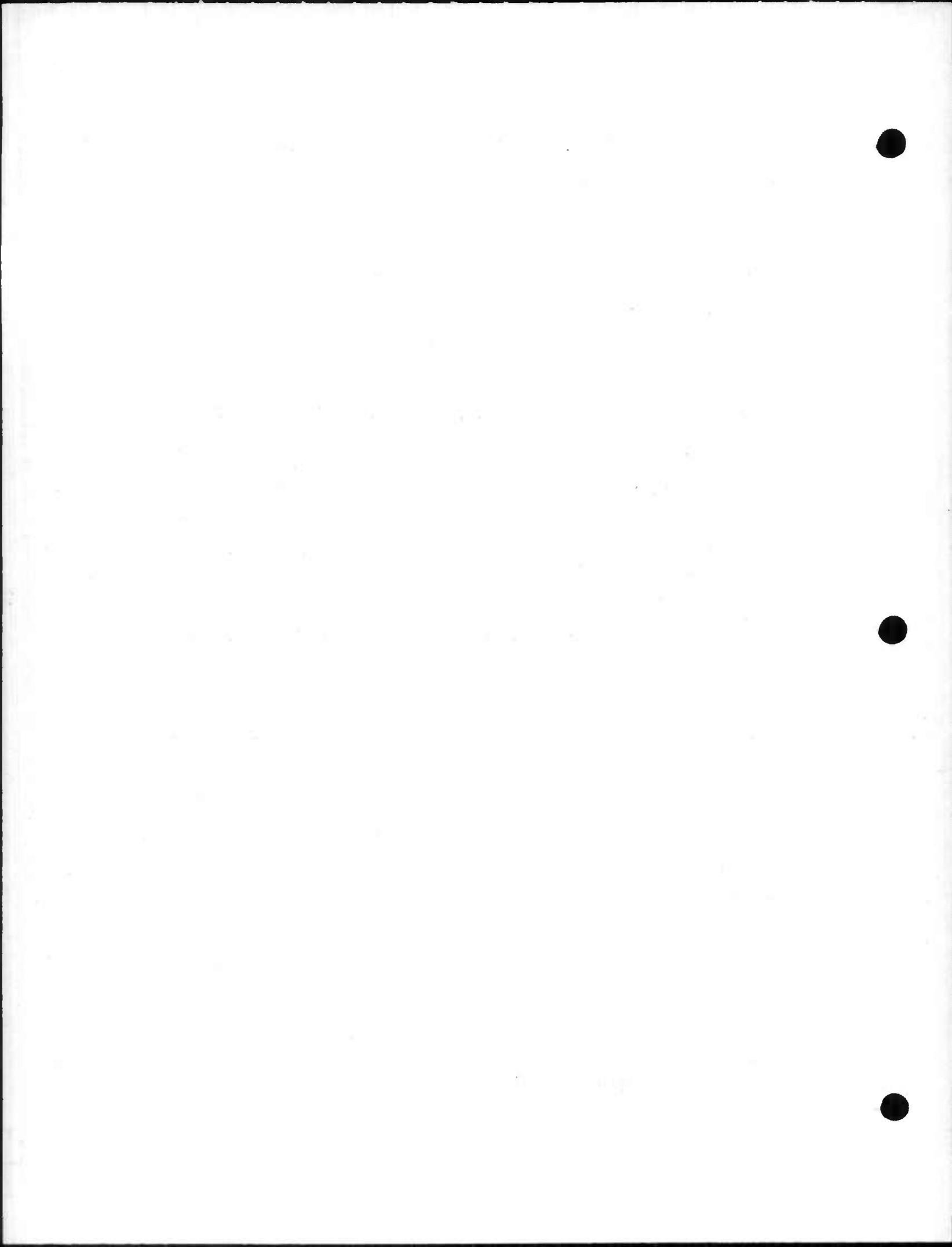
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH June DAY 25, 1995 YEAR								3. TIME OF DEATH 11:15 A M	
1. DECEDENT'S NAME (First, Middle, Last) CATHERINE E. KAMMAR										7. DATE OF BIRTH (Month, Day, Year) Sept. 1, 1907	
4. SOCIAL SECURITY NUMBER 215-05-9857		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Meridian-Cromwell		9b. CITY, TOWN OR LOCATION OF DEATH Towson								9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2918 Pinewood Ave.				10f. ZIP CODE 21214				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Exec. Administrative Asst.				16b. KIND OF BUSINESS/INDUSTRY Construction Co.					
17. FATHER'S NAME (First, Middle, Last) Philip Kammar										18. MOTHER'S NAME (First, Middle, Maiden Surname) Mae Marie Bach	
19a. INFORMANT'S NAME (Type/Print) Theodore M. Kammar					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 201 Brandon Rd., Baltimore, MD 21212						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery, or other place) Loudon Park Cemetery					DATE 6/29	20c. LOCATION — City or Town, State Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY ALTENBURG FUNERAL HOME, P.A.						
					6009 Harford Rd., Baltimore, MD 21214						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Arterosclerotic coronary artery disease</i>											
b. DUE TO (OR AS A CONSEQUENCE OF): <i>Arterosclerotic coronary artery disease</i>											
c. DUE TO (OR AS A CONSEQUENCE OF): <i>Arterosclerotic coronary artery disease</i>											
d. DUE TO (OR AS A CONSEQUENCE OF): <i>Arterosclerotic coronary artery disease</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marion Kowalewski MD</i>		29c. LICENSE NUMBER A21022								29d. DATE SIGNED (Month, Day, Year) 6-26-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARION KOWALEWSKI, 8604 HARFORD RD 21234											
31. DATE FILED ON JUN 26 1995											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

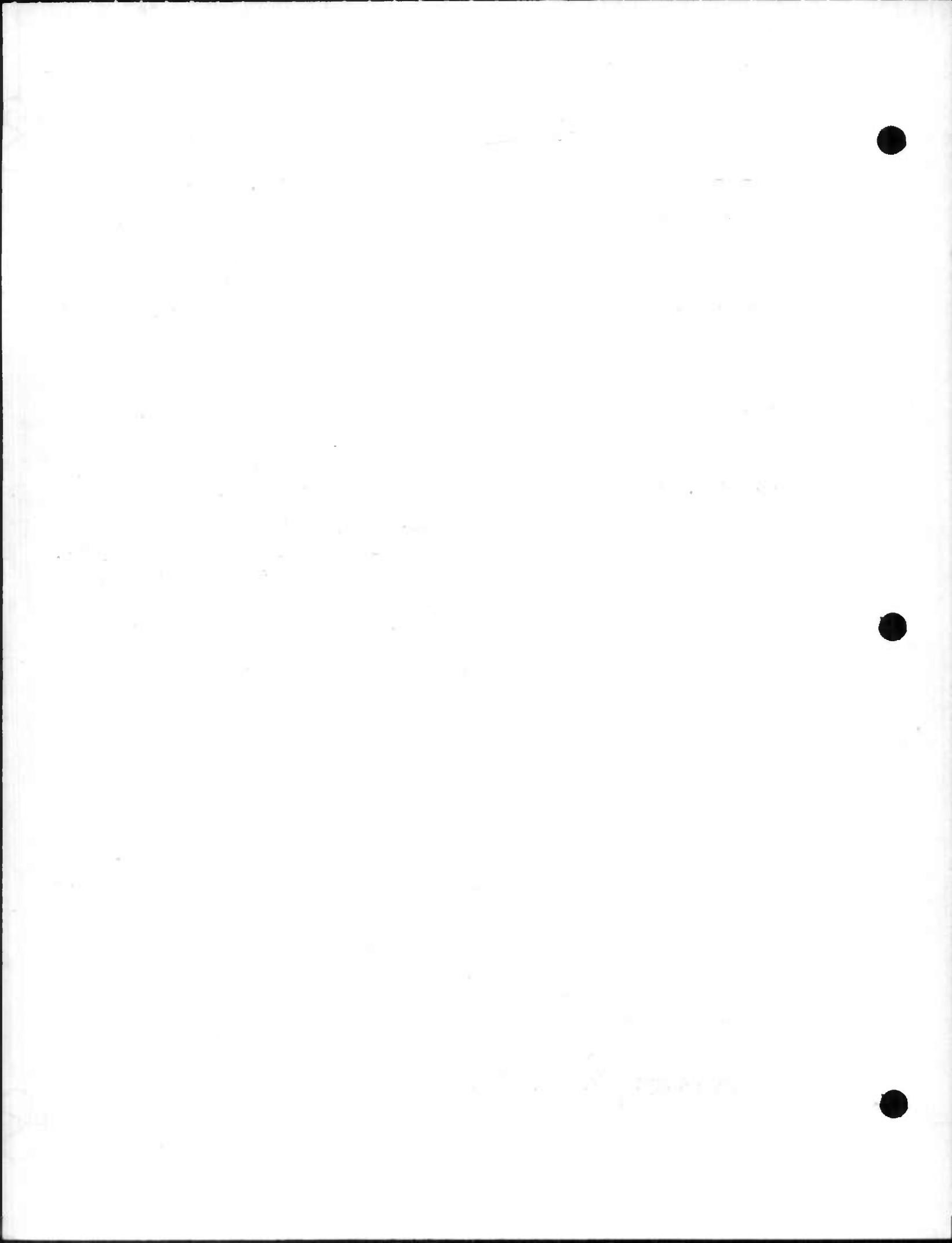
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 95 19276	
1. DECEDENT'S NAME (First, Middle, Last)			HENRY WALTER Walter Henry Kluver						2. DATE OF DEATH MONTH 6 DAY 20 YEAR 95			3. TIME OF DEATH 5:41 p.m.	
4. SOCIAL SECURITY NUMBER 219-28-3637			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 62 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS		IF UNDER 24 HRS. HOURS 0 MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 8, 1932			8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 321 Redbud Road			9b. CITY, TOWN OR LOCATION OF DEATH Edgewood						9c. COUNTY OF DEATH Harford				
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Edgewood						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 321 Redbud Road			10f. ZIP CODE 21040						10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (14 or 5+) 8 Years			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance						16b. KIND OF BUSINESS/INDUSTRY Shopping Ctr.				
17. FATHER'S NAME (First, Middle, Last) Peter Kluver						18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Ward							
19a. INFORMANT'S NAME (Type/Print) Estelle D. Kluver						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 321 Redbud Road Edgewood, Maryland 21040							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crest Lawn Cemetery 6/23/95			DATE			20c. LOCATION — City or Town, State Sykesville, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Sonja Deane			22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 1922 Wise Ave Dundalk, Maryland 21222										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												MONTHS	
a. CANCER OF THE LUNG DUE TO (OR AS A CONSEQUENCE OF):													
b. ARTERIOSCLEROTIC HEART DISEASE DUE TO (OR AS A CONSEQUENCE OF):												YEARS	
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. C. VA. CA COLON												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER B.C. VERACACION JR MD PA			29c. LICENSE NUMBER D13664						29d. DATE SIGNED (Month, Day, Year) ► 6-21-95				
29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B.C. VERACACION JR MD 1516 MERRITT BLVD STE 22 BALTIMORE MD 21222													
31. DATE FILED (Month, Day, Year) JUN 26 1995			32. REGISTRAR'S SIGNATURE John Deane, R.R. 1										



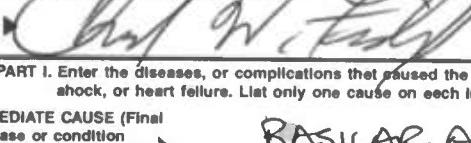
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

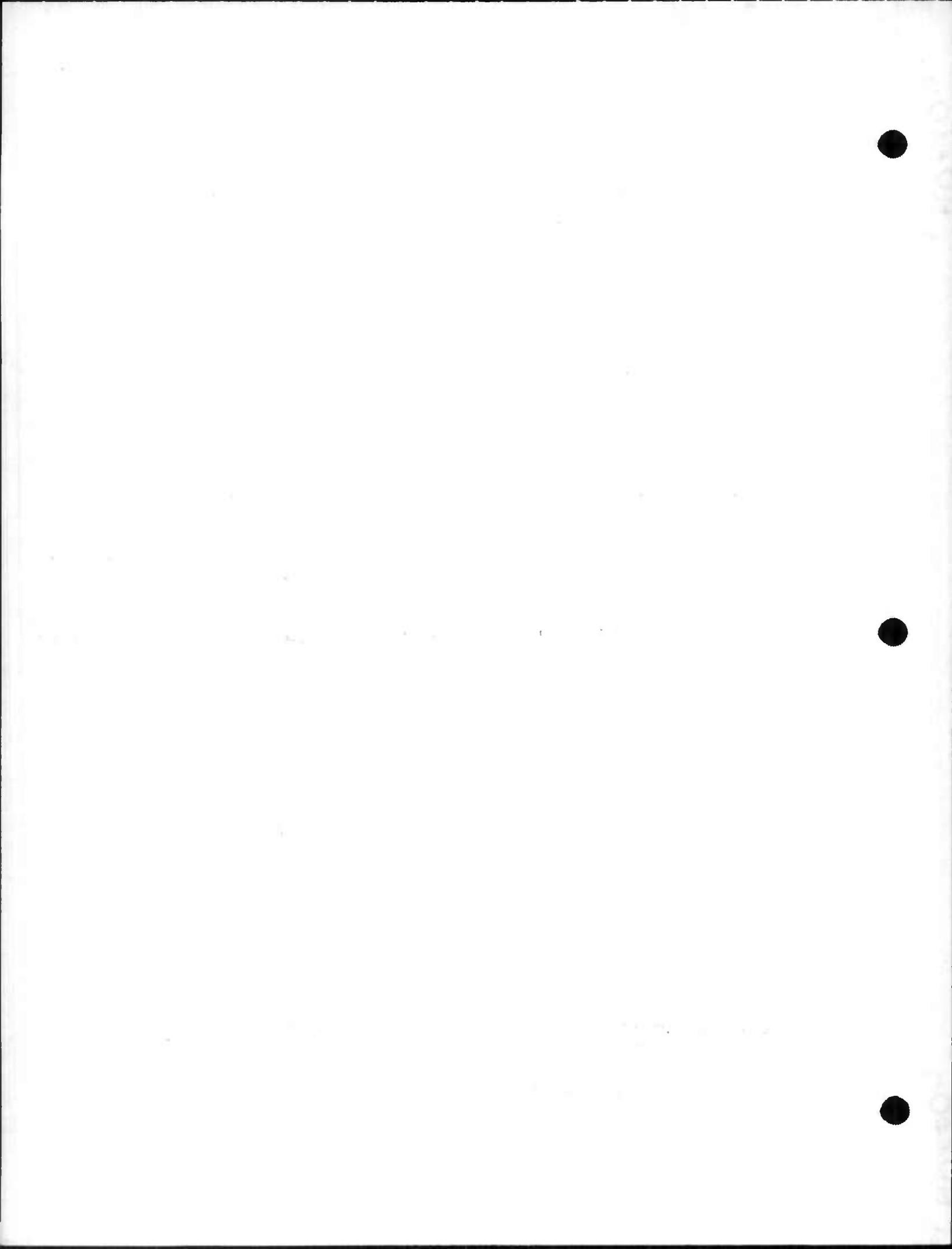
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) GORDON KENNETH LEE										2. DATE OF DEATH MONTH JUNE DAY 22 YEAR 1995		3. TIME OF DEATH 10:58 PM
4. SOCIAL SECURITY NUMBER 213-07-7250		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 22, 1914		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Nursing Ctr.										9b. CITY, TOWN OR LOCATION OF DEATH Towson		
9c. COUNTY OF DEATH Baltimore												
RESIDENCE OF DECEASED												
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Edgemere				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 X NO						
10e. STREET AND NUMBER 7701 Bayfront Road					10f. ZIP CODE 21219			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 X NO IF YES, GIVE WAR OR DATES 12 Years			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 X NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify:				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12)			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Foreman			16b. KIND OF BUSINESS/INDUSTRY Steel Industry						
17. FATHER'S NAME (First, Middle, Last) George William Lee					18. MOTHER'S NAME (First, Middle, Maiden Surname) Ermine Unknown							
19a. INFORMANT'S NAME (Type/Print) Mrs. Eunice V. Lee					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7701 Bayfront Road Edgemere, Maryland 21219							
20a. METHOD OF DISPOSITION H X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery			DATE 6/26/95	20c. LOCATION — City or Town, State Baltimore, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) → BASILAR ARTERY THROMBOSIS												
DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____												
Approximate Interval Between Onset and Death 1 month												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 X Other (Specify)										
27. MANNER OF DEATH 1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Faulkner MD					29c. LICENSE NUMBER D25643			29d. DATE SIGNED (Month, Day, Year) ► 6/23/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204												
31. DATE FILED (Month, Day, Year) JUN 26 1995					32. REGISTRAR'S SIGNATURE [Signature]							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial; cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

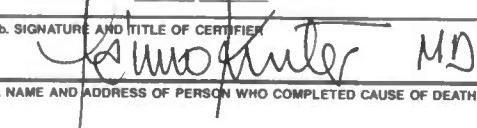
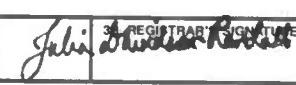
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19278

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH June DAY 22 YEAR 1995	3. TIME OF DEATH 9:30 A.M.
FRANCES JEANETTE LEONARD						7. DATE OF BIRTH (Month, Day, Year) June 12, 1922	
4. SOCIAL SECURITY NUMBER 214-14-7227		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) 793 Bittersweet Lane						9b. CITY, TOWN OR LOCATION OF DEATH Sykesville	
9c. COUNTY OF DEATH Carroll							
10a. STATE Md.	10b. COUNTY Carroll	10c. CITY, TOWN OR LOCATION Sykesville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 793 Bittersweet Lane				10f. ZIP CODE 21784		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary			16b. KIND OF BUSINESS/INDUSTRY Western High School		
17. FATHER'S NAME (First, Middle, Last) George Alban				16. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Rose			
19a. INFORMANT'S NAME (Type/Print) Mrs. Anita Amrhine				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 627 Goucher Ave. Lutherville, Md. 21093			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Corp.			DATE 6/26/95	20c. LOCATION — City or Town, State Towson, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC BREAST CANCER Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH Natural Accident Suicide Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD						29c. LICENSE NUMBER J35398	29d. DATE SIGNED (Month, Day, Year) 6/22/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FLAVIO KRUTER, MD. 684 POOLE ROAD, SUITE A WESTMINSTER, MARYLAND 21157							
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR SIGNATURE 					

WESTMINSTER, MARYLAND 21152
68A POOLE ROAD, SUITE A
FLANDERS MURKIN, MD.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

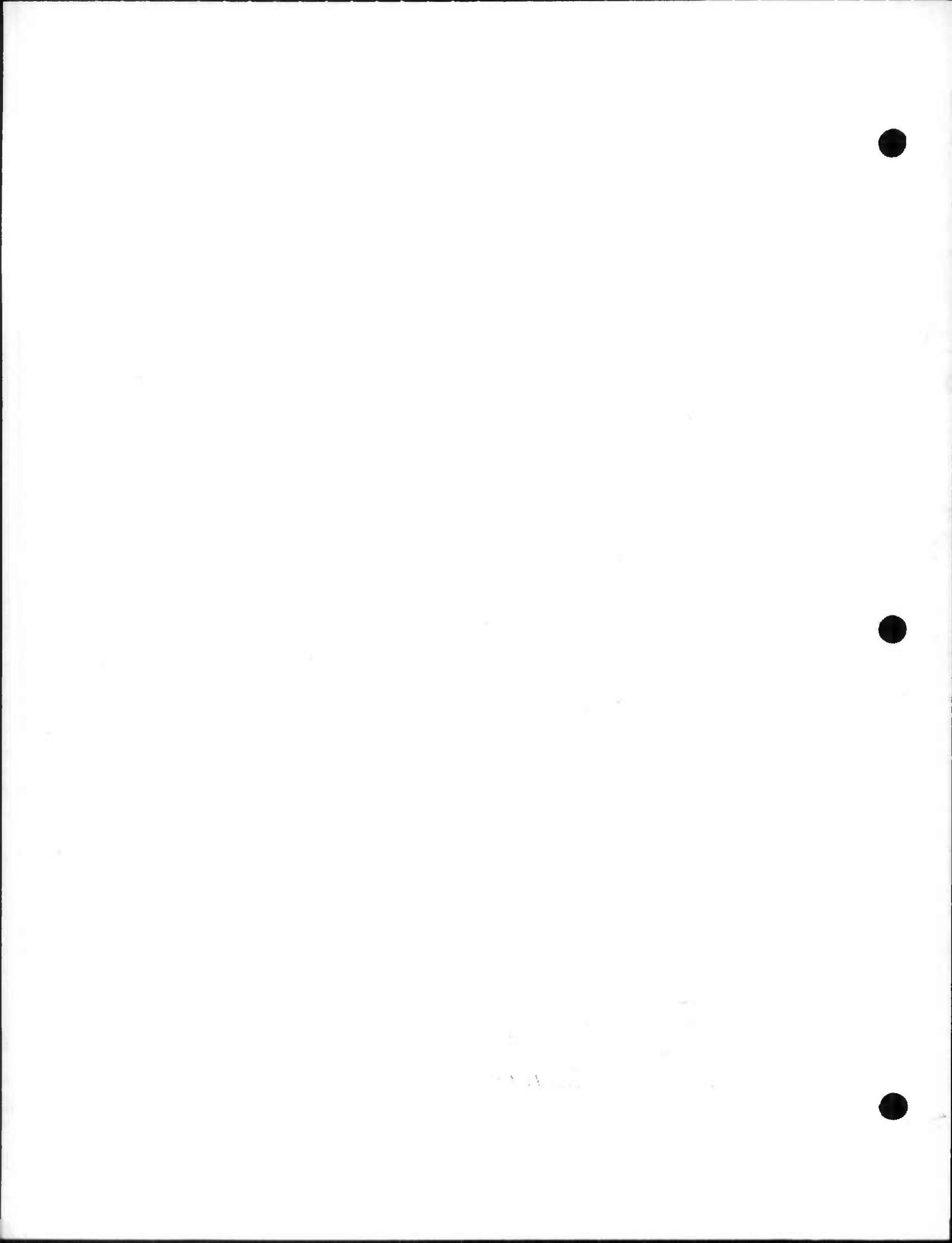
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR												
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
Olinda		Elizabeth		LAUMAN		June 23, 1995				2:30 P M		
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
216-52-6132		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		83 YRS.		MONTHS		DAYS		Feb. 25, 1912		Maryland
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH
Franklin Square Hospital										Baltimore		Baltimore County
RESIDENCE OF DECEDENT												
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
Maryland		Baltimore		Baltimore								
10e. STREET AND NUMBER										10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?
7517 Kenlea Avenue										21236		U.S.A.
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (8-12) 8th Grade		Home Maker								own home		
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)		
George Harmeyer										Helena Solze		
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)		
Lois Marie Diepold										7413 Brookwood Avenue Baltimore, Maryland-21236		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)								DATE	20c. LOCATION — City or Town, State	
		Gardens of Faith Cemetery								6/27	Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										22. NAME AND ADDRESS OF FACILITY		
<i>Kathleen M. Murphy</i>										6415 Belair Road John C. Miller, Inc. Baltimore, Maryland 21206		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Perforated viscus										1 day		
b. Acute Abdomen DUE TO (OR AS A CONSEQUENCE OF):										1 day		
c. Metastatic adeno carcinoma DUE TO (OR AS A CONSEQUENCE OF):												
d. Neuroendocrine gastrointestinal tumor												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)										
		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide												
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Franklin Joseph Velez</i>										29c. LICENSE NUMBER D 347 37		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										29d. DATE SIGNED (Month, Day, Year) ► 6/23/95		
Franklin Joseph Velez MD 9000 franklin Sq. Dr. Baltimore, Maryland 21237												
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Juli</i>										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

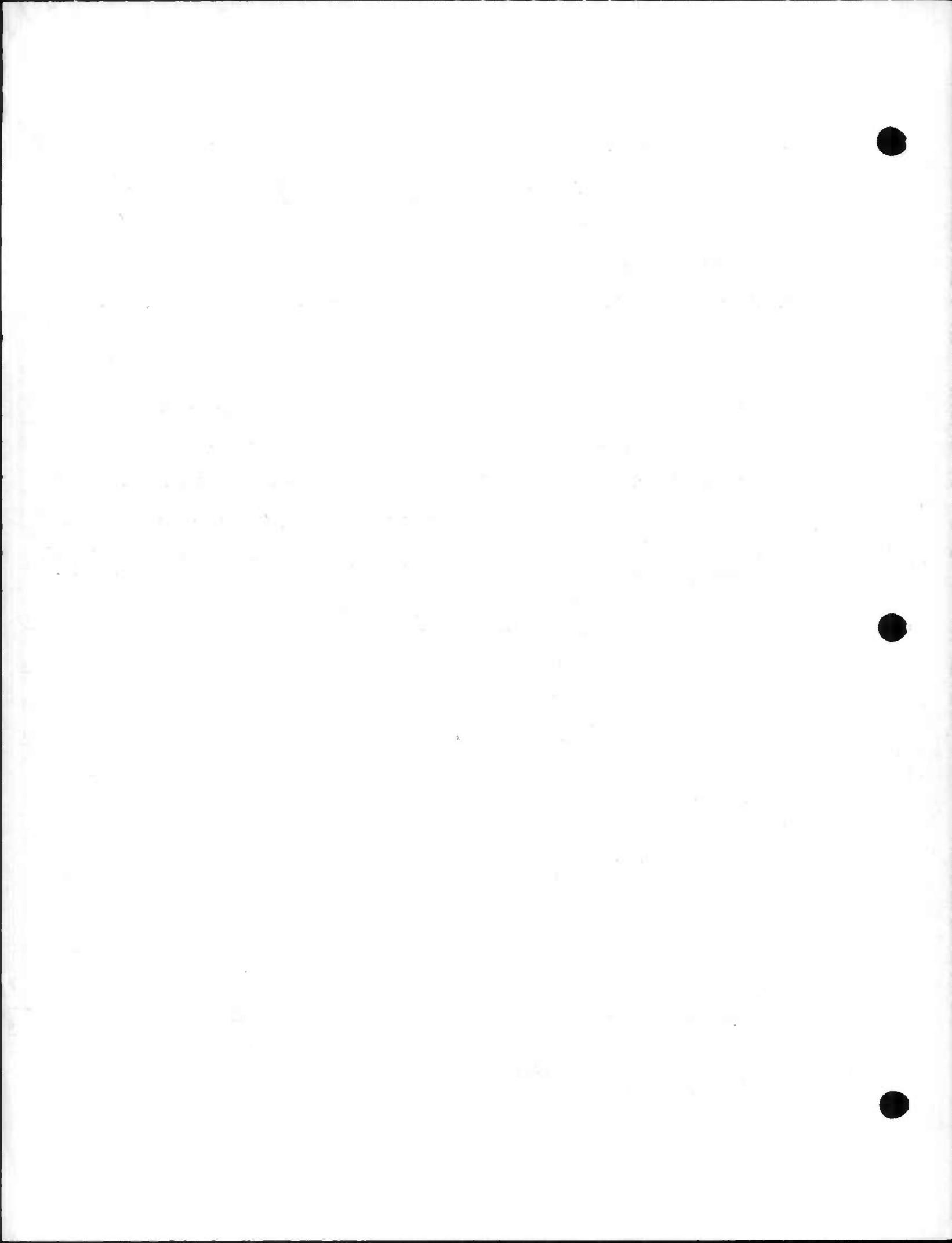
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.
1. DECEASED'S NAME (First, Middle, Last)		JUNE 23 1995						554P ^m		3. TIME OF DEATH
HAZEL V. LESER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) October 31, 1924		8. BIRTHPLACE (State or Foreign Country) MARYLAND
14. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore						9c. COUNTY OF DEATH N/A		
RESIDENCE OF DECEASED		10e. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 1411 OAKDALE ROAD		10f. ZIP CODE 21060						10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0 CLERK		16b. KIND OF BUSINESS/INDUSTRY SAVINGS BANK						
17. FATHER'S NAME (First, Middle, Last) GEORGE W. COLLINS		18. MOTHER'S NAME (First, Middle, Maiden Surname) MOLLY LATHE								
19a. INFORMANT'S NAME (Type/Print) LINDA G. BARBEE		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1411 OAKDALE ROAD-GLEN BURNIE, MD. 21060								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERANS						DATE 6/27	20c. LOCATION — City or Town, State CROWNSVILLE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Hazel Stoy		22. NAME AND ADDRESS OF FACILITY RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.								
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. END STAGE GLOBAL HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):										1 year
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. Acute Renal Failure DUE TO (OR AS A CONSEQUENCE OF): d. Possible Sepsis										15 years
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Undetermined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER Check only one: 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER Hazel Asinader, MD		29c. LICENSE NUMBER AS24461447						29d. DATE SIGNED (Month, Day, Year) ► June 23, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hazel Asinader, MD, Harbor Hospital Center		3001 S. Hanover Street Baltimore, MD 21225								
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. OTHER SIGNATURE								



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

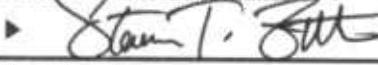
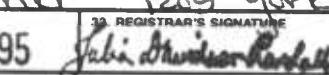
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

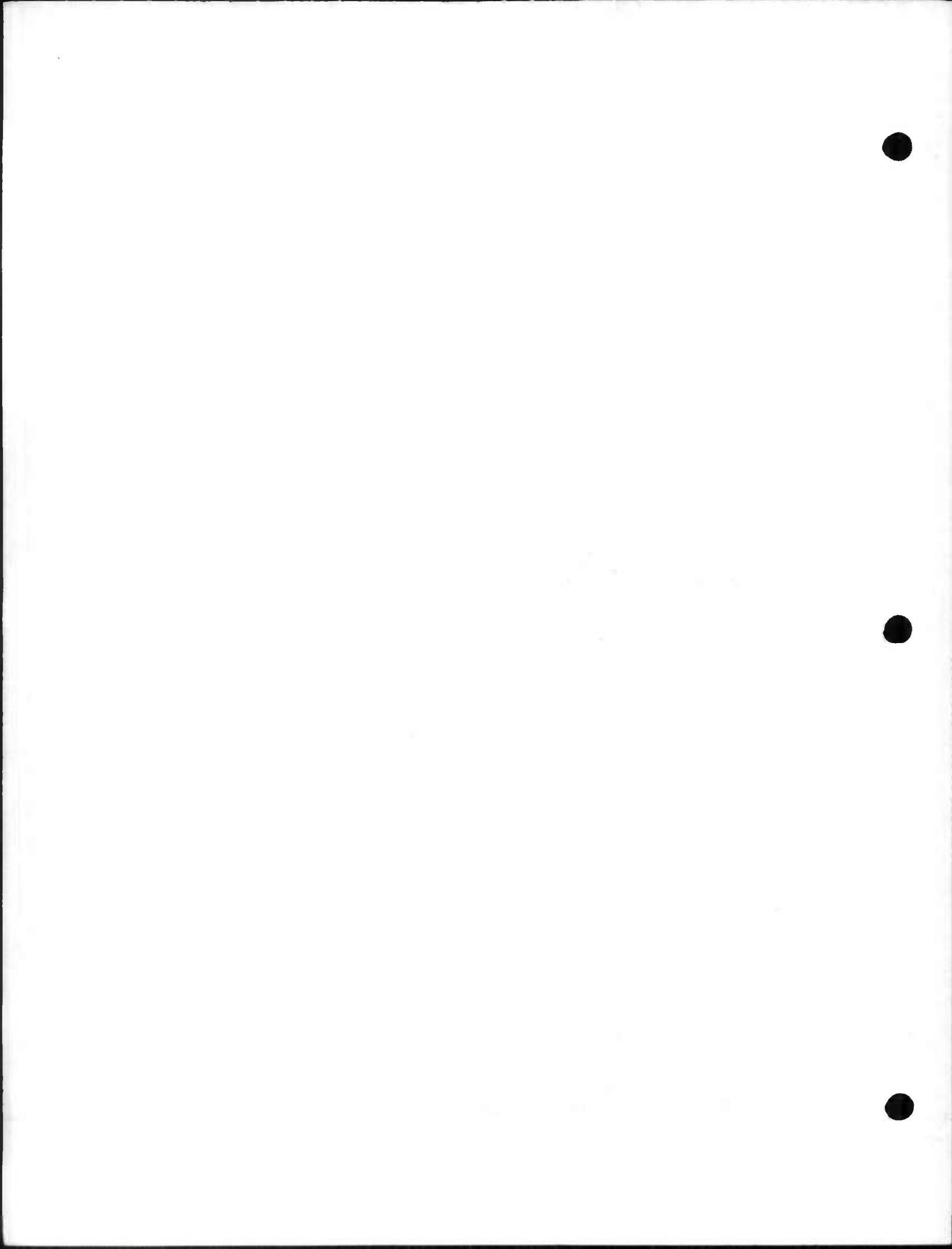
TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19281

1. DECEDENT'S NAME (First, Middle, Last) Glayds Viola Mallonee						2. DATE OF DEATH MONTH 06 DAY 23 YEAR 95	3. TIME OF DEATH 4:45PM M
4. SOCIAL SECURITY NUMBER 216-03-3779		5. SEX M	6. AGE (In yrs. last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) 07/13/1904	8. BIRTHPLACE (State or Foreign Country) Baltimore
9a. FACILITY NAME (If not institution, give street and number) Maryland Masonic Home				9b. CITY, TOWN OR LOCATION OF DEATH Cockeysville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Cockeysville				10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10e. STREET AND NUMBER 300 International Circle				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		12. WAS DECEDENT EVER IN U.S. ARMEO FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES 12			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) Earle Martin Mallonee				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna Henrietta Burton			
19a. INFORMANT'S NAME (Type/Print) Maryland Masonic Homes				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 International Circle Cockeysville, MD 21030			
20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Loudon Park Cemetery			DATE 6/26	20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Road Baltimore, MD 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
<p>a. <i>Thrombotic thrombocytopenic purpura</i> DUE TO (DR AS A CONSEQUENCE OF):</p> <p>b. { DUE TO (DR AS A CONSEQUENCE OF):</p> <p>c. { DUE TO (DR AS A CONSEQUENCE OF):</p> <p>d. {</p>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <input type="checkbox"/>					
27. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 040208		29d. DATE SIGNED (Month, Day, Year) 6/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) June Breiner 125 York Rd Lutherville Md 21093				31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

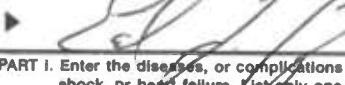
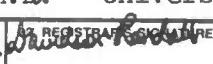
TO BE COMPLETED BY FUNERAL DIRECTOR

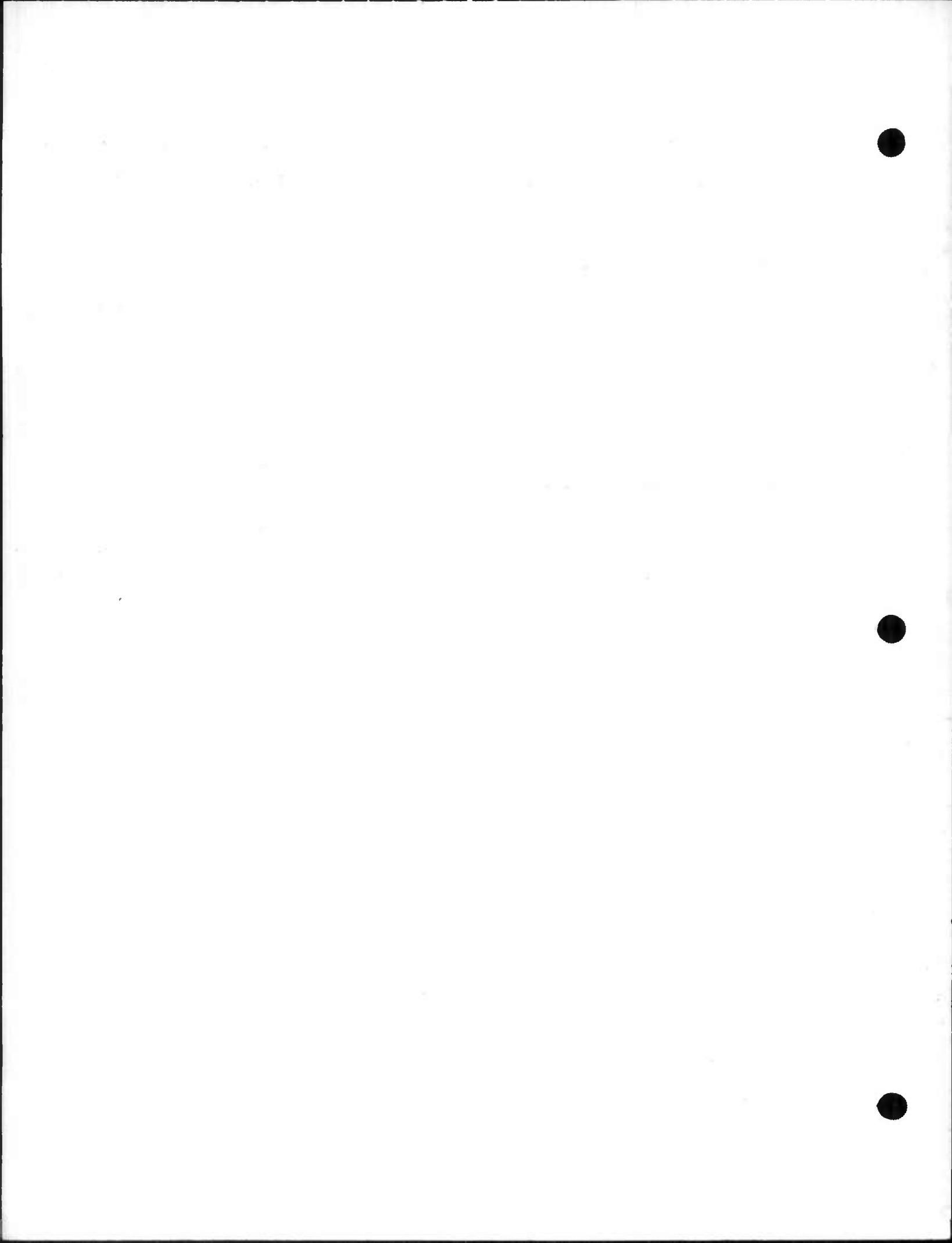
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 1928

1. DECEDENT'S NAME (First, Middle, Last) Mary L. Meiller		2. DATE OF DEATH MONTH June DAY 22 YEAR 1995		3. TIME OF DEATH 8:03 A.M.
4. SOCIAL SECURITY NUMBER 213-05-2131		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0
9a. FACILITY NAME (If not institution, give street and number) 1209 Clearfield Circle		9b. CITY, TOWN OR LOCATION OF DEATH Lutherville		9c. COUNTY OF DEATH Baltimore
RESIDENCE OF DECEDENT				
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 3 Southerly Court			10f. ZIP CODE 21286	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home
17. FATHER'S NAME (First, Middle, Last) James B. Mann			16. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Lotz	
19a. INFORMANT'S NAME (Type/Print) Timothy F. Meiller, D.D.S.			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1209 Clearfield Circle Lutherville, Md. 21093	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem.		DATE 6/26/95 20c. LOCATION — City or Town, State Baltimore, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY 1050 York Rd Ruck Towson Funeral Home, Inc. Towson, Md.		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SUBACUTE RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. MULTIPLE MYELOMA DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____				
Approximate Interval Between Onset and Death 8 WKS				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide	28a. DATE OF INJURY (Month, Day, Year) 4/9	28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED At home, farm, street, factory, office building, etc. (Specify)
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) University Hospital Floor 9D Baltimore, Maryland 21201		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. LICENSE NUMBER D08246		
29a. CERTIFIER (Check only one) 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. DATE SIGNED (Month, Day, Year) 6/23/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Meyer R. Heyman, M.D.		31. DATE FILED (Month, Day, Year) JUN 26 1995		
32. REGISTRAR'S SIGNATURE 				



DIVISION OF VITAL RECORDS, P.O. BOX 687600

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. To THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY FUNERAL DIRECTOR

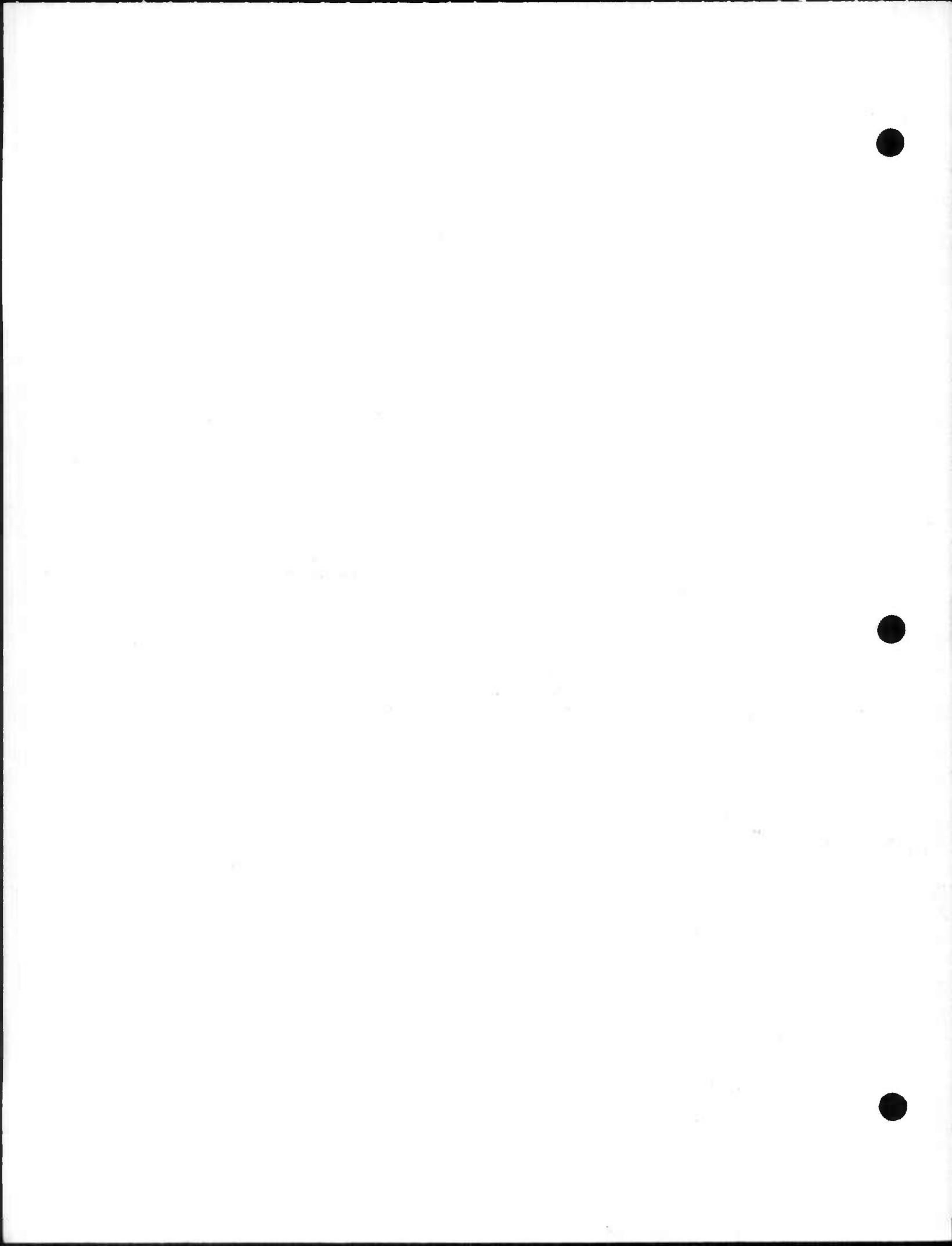
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19283

1. DECEDENT'S NAME (First, Middle, Last) EARL MCCARDLE				2. DATE OF DEATH MONTH JUNE DAY 20, 1995 YEAR	3. TIME OF DEATH 9:30A M
4. SOCIAL SECURITY NUMBER 188-07-3263		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		7. DATE OF BIRTH (Month Day Year) June 15, 1915			
9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		8. BIRTHPLACE (State or Foreign Country) Penn.			
9c. COUNTY OF DEATH N/A					
10a. STATE Penn.		10b. COUNTY Snyder Co.		10c. CITY, TOWN OR LOCATION Middleburg	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
10e. STREET AND NUMBER RD.1Box 404		10f. ZIP CODE 17842		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Owner/Operator, Bar		16b. KIND OF BUSINESS/INDUSTRY Bar	
17. FATHER'S NAME (First, Middle, Last) John Henry McCardle		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Knepp			
19a. INFORMANT'S NAME (Type/Print) Mr. Larry McCardle		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RD 1 Box 404 Middleburg, Pa. 17842			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Juniata Memorial Park		DATE 6-24-95	20c. LOCATION — City or Town, State Lewistown, Pa.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
<p>e. Hypoxia DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Adult Respiratory Disease Syndrome DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. Myocardial Ischemia DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>					
Approximate Interval Between Onset and Death 25 min					
Approximate Interval Between Onset and Death 48 hrs					
Approximate Interval Between Onset and Death 25 min					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/p CABG, hypertension, s/p PCTA, CHF, mitral regurg., LBB bundle branch block					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> ND
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER BY2065779		29d. DATE SIGNED (Month, Day, Year) 6/20/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Yang, MD, Johns Hopkins Hospital					
31. DATE FILED (Month Day Year) JUN 26 1995 John W. Jackson, Esquire					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

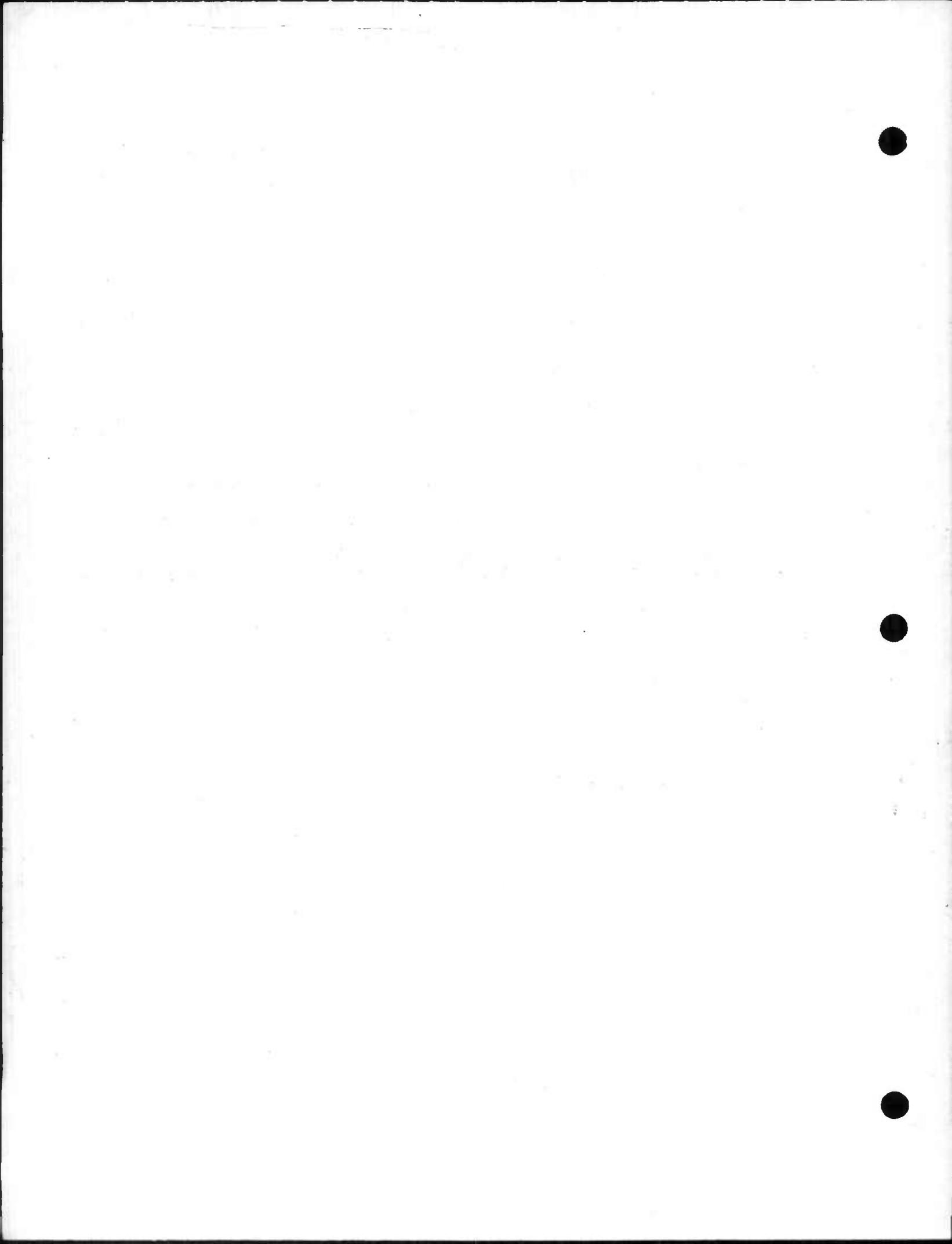
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH
WILLIE MCCOY										JUNE 19 1995		8:40 P M
4. SOCIAL SECURITY NUMBER 214-26-6052		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec 15 1931		8. BIRTHPLACE (State or Foreign Country) S.C.	
9a. FACILITY NAME (If not institution, give street and number) MARYLAND GENERAL HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		
9c. COUNTY OF DEATH N/A												
RESIDENCE OF DECEDENT												
10a. STATE Md	10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2941 Belmont Avenue					10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? U S A			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) N/A			16b. KIND OF BUSINESS/INDUSTRY Private Duty Nursing							
17. FATHER'S NAME (First, Middle, Last) Thomas Roe					18. MOTHER'S NAME (First, Middle, Maiden Surname) Flora Roe							
19e. INFORMANT'S NAME (Type/Print) Rupert McCoy					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2941 Belmont Avenue Baltimore, Md 21216							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet			DATE	20c. LOCATION — City or Town, State 62695 Owings Mills, Md			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glynis B. Scott</i>					22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore, Md 21215							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS, RENAL FAILURE, RESPIRATORY DISTRESS UNKNOWN DUE TO (OR AS A CONSEQUENCE OF):												
b. _____ DUE TO (OR AS A CONSEQUENCE OF):												
c. _____ DUE TO (OR AS A CONSEQUENCE OF):												
d. _____												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, ADVANCE CARDIAC DISEASE WITH ARRHYTHMIA, MULTIPLE CEREBROVASCULAR ACCIDENT										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month, Day, Year) <i>6/19/95</i>		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ruby Jean Toehio</i>		29c. LICENSE NUMBER 89230										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RUBY JEAN TOEHIO, MD C/O MARYLAND GENERAL HOSPITAL 827 LINDEN AVE												
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Juli A. Decker-Randall</i>								DHMH-18 Rev 1/90		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Sonia Marie Morley										2. DATE OF DEATH MONTH DAY YEAR June 21, 1995	3. TIME OF DEATH 2150
4. SOCIAL SECURITY NUMBER 218-28-2878		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 63	7. IF UNDER 1 YEAR MONTHS YRS.	8. IF UNDER 24 HRS. HOURS MIN.	9. BIRTHPLACE (State or Foreign Country) March 30, 1932 Maryland					
9a. FACILITY NAME (If not institution, give street and number) Atlantic General Hospital				9b. CITY, TOWH OR LOCATION OF DEATH Berlin		9c. COUNTY OF DEATH Worcester					
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Dundalk			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER 518 Bayside Drive				10f. ZIP CODE 21222		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY Own Home						
17. FATHER'S NAME (First, Middle, Last) John Albert Oliver		18. MOTHER'S NAME (First, Middle, Maiden Surname) Agnes C. Morrissey									
19a. INFORMANT'S NAME (Type/Print) Mr. James H. Morley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 518 Bayside Drive Dundalk, Maryland 21222									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Cem.			DATE 6/26/95	20c. LOCATION — City or Town, State Elkridge, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charl W. Lally		22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		s. <i>Cardiac arrest</i> DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Hypertension</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6-21-95		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. A. G. H. E.D.</i>					29c. LICENSE NUMBER D 44108			29d. DATE SIGNED (Month, Day, Year) ► 6-21-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>J. A. G. H. E.D.</i>											
31. DATE FILED (Month, Day, Year) 6-21-95		32. RECORDER'S SIGNATURE <i>J. A. G. H. E.D.</i>									

from our
Gardens

W. H. Bishop

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

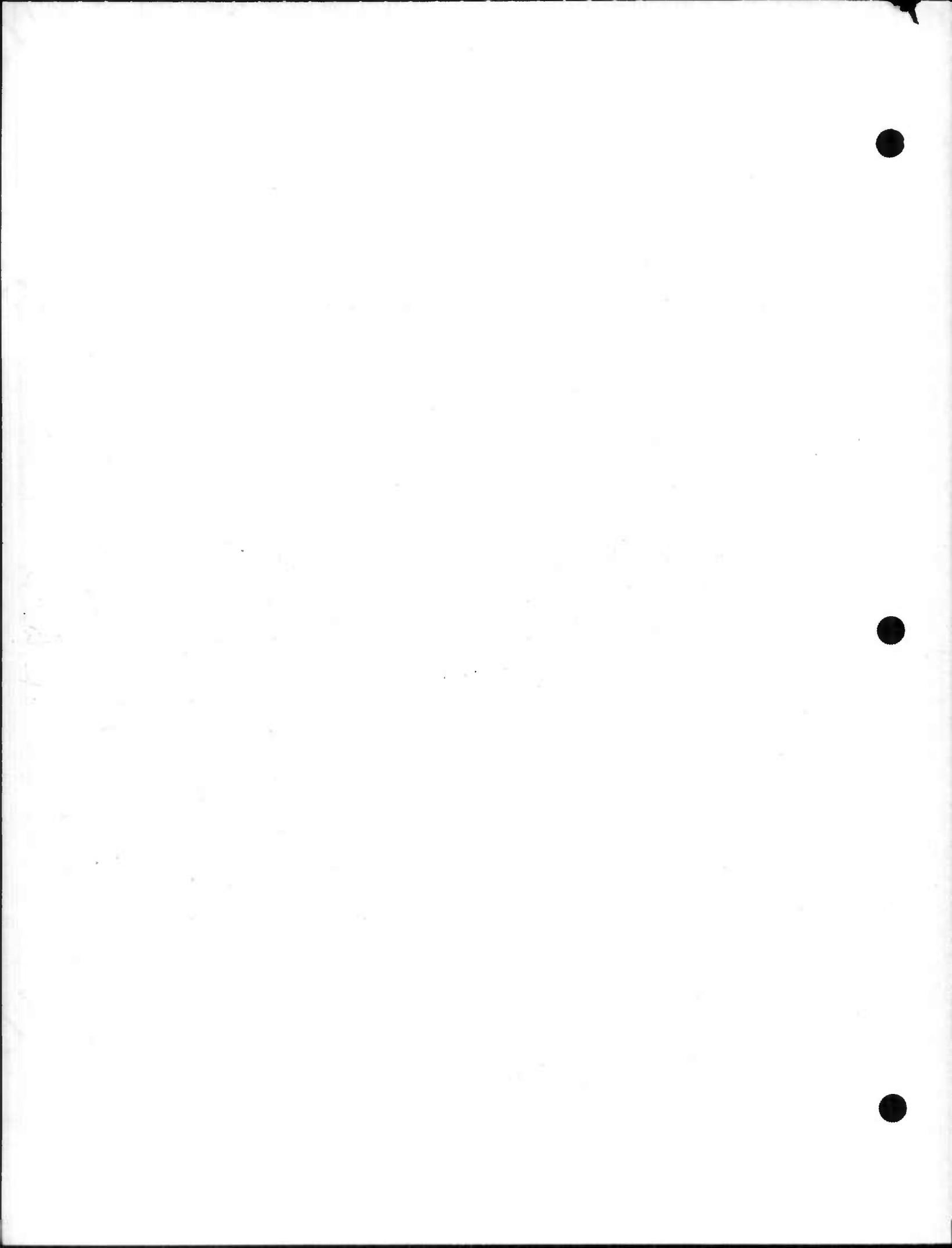
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) HELEN L. MARSH										2. DATE OF DEATH MONTH DAY YEAR JUNE 19, 1995	3. TIME OF DEATH 1 A. M
4. SOCIAL SECURITY NUMBER 231-66-1253		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) FEBRUARY 9, 1916		8. BIRTHPLACE (State or Foreign Country) WASHINGTON, DC			
9a. FACILITY NAME (If not institution, give street and number) GOLDEN OAKS CONVALESCENT CENTER										9b. CITY, TOWN OR LOCATION OF DEATH LAUREL,	9c. COUNTY OF DEATH PRINCE GEORGE
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND	10b. COUNTY PRINCE GEORGE	10c. CITY, TOWN OR LOCATION BELTSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10g. CITIZEN OF WHAT COUNTRY? USA			
10e. STREET AND NUMBER 10301 #T1 45th Place				10f. ZIP CODE 20705							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: 			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Ø HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY HOME						
17. FATHER'S NAME (First, Middle, Last) JOHN EDWARD BOLE				18. MOTHER'S NAME (First, Middle, Maiden Surname) NELLIE CATHERINE HILL							
19a. INFORMANT'S NAME (Type/Print) M. THERESA DERENBERGER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15640 MEWS COURT, LAUREL, MARYLAND 20707							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) MT. OLIVET				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. OLIVET				DATE 16/23	20c. LOCATION — City or Town, State WASHINGTON, DC		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Gladys Leadley				22. NAME AND ADDRESS OF FACILITY FLECK FUNERAL HOME, INC. 7601 SANDY SPRING ROAD, LAUREL, MARYLAND 20707							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 24 hrs	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac Congestive Heart Failure											
b. Artery Disease DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				OTHER: M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 		28b. TIME OF INJURY M 	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 	28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER ► Gladys Leadley				29c. LICENSE NUMBER 025430		29d. DATE SIGNED (Month, Day, Year) ► 6/19/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14333 Laurel Bowie Rd #307 Laurel, MD 20708											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRATION NUMBER Julia Daniels									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

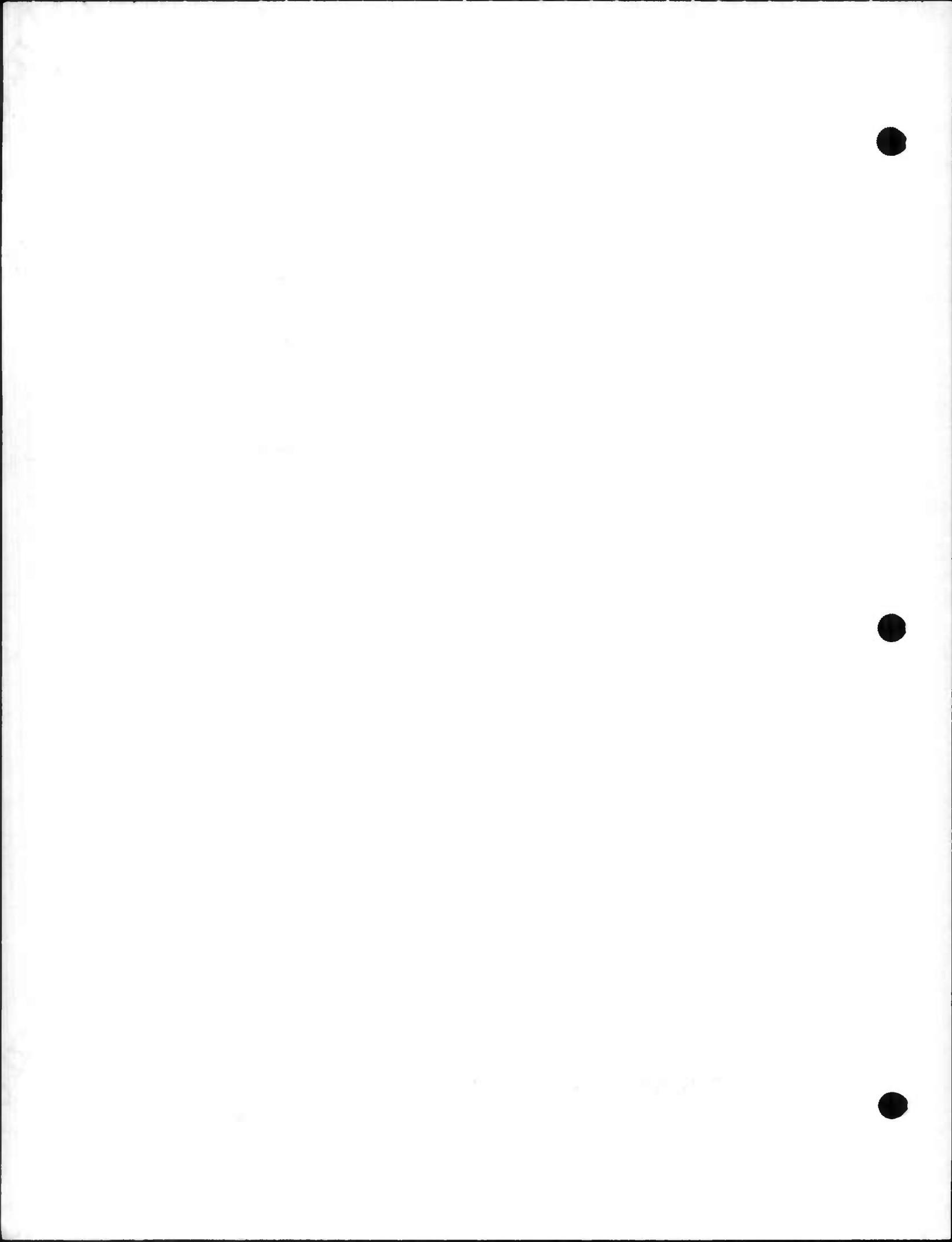
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
REG. NO. 95 19287											
<p>1. DECEDENT'S NAME (First, Middle, Last) VIOLA MOORE</p> <p>4. SOCIAL SECURITY NUMBER 219-07-4431 5. SEX M 6. AGE (In yrs. last birthday) 89 YRS.</p> <p>7. DATE OF BIRTH (Month, Day, Year) JULY 16, 1905 8. BIRTHPLACE (State or Foreign Country) VIRGINIA</p> <p>2. DATE OF DEATH MONTH JUNE DAY 17 YEAR 1995 3. TIME OF DEATH 6:25 AM</p> <p>9a. FACILITY NAME (If not institution, give street and number) 2154 HOLLINS STREET</p> <p>9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE</p> <p>9c. COUNTY OF DEATH N/A</p> <p>10a. STATE MARYLAND 10b. COUNTY N/A</p> <p>10c. CITY, TOWN OR LOCATION BALTIMORE</p> <p>10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/></p> <p>10e. STREET AND NUMBER 2154 HOLLINS STREET</p> <p>10f. ZIP CODE 21223</p> <p>10g. CITIZEN OF WHAT COUNTRY? USA</p> <p>11. MARITAL STATUS Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced <input type="checkbox"/></p> <p>12. WAS DECEDENT EVER IN U.S. ARMED FORCES? NO <input checked="" type="checkbox"/> YES <input type="checkbox"/></p> <p>13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO <input checked="" type="checkbox"/> YES <input type="checkbox"/></p> <p>14. RACE — American Indian, Black, White, etc. Specify: BLACK</p> <p>15. DECEDENT'S EDUCATION (Specify only highest grade completed) 5TH GRADE</p> <p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER</p> <p>16b. KIND OF BUSINESS/INDUSTRY FEDERAL TIN COMPANY</p> <p>17. FATHER'S NAME (First, Middle, Last) UNKNOWN Henry Riddick</p> <p>18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN Josephine (MN-unknown)</p> <p>19a. INFORMANT'S NAME (Type/Print) JOSEPHINE TOLIVER</p> <p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2154 HOLLINS ST., BALTIMORE, MD. 21223</p> <p>20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/></p> <p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY</p> <p>DATE 6-23-95</p> <p>20c. LOCATION — City or Town, State BALTIMORE, MD.</p> <p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE S. H. Brown Jr.</p> <p>22. NAME AND ADDRESS OF FACILITY JOSEPH H. BROWN JR. FUNERAL HOME, P.A.</p> <p>1913 W. BALTIMORE ST., BALTIMORE, MD. 21223</p> <p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. Cancer Bladder. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Anemia. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. A tube feeding. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. </p> <p>Approximate Interval Between Onset and Death 6as Then 2 months</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>24a. WAS AN AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/></p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/></p> <p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>Dementia Bilateral Blind eyes</p> <p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH UNCERTAIN <input checked="" type="checkbox"/></p> <p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/></p> <p>26. PLACE OF DEATH (Check only one) HOSPITAL: NO <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA Residence <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Other (Specify)</p> <p>27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> 4 <input type="checkbox"/> Homicide </p> <p>28a. DATE OF INJURY (Month, Day, Year)</p> <p>28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>28c. INJURY AT WORK? NO <input type="checkbox"/></p> <p>28d. DESCRIBE HOW INJURY OCCURRED</p> <p>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p> <p>29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>29b. SIGNATURE AND TITLE OF CERTIFIER Suresh K. Tripathaneni</p> <p>29c. LICENSE NUMBER D 30661</p> <p>29d. DATE SIGNED (Month, Day, Year) June 20th 1995</p> <p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SURESH K. TRIPATHANENI, 1940 W. Baltimore, Md. 21223</p> <p>31. DATE FILED (Month, Day, Year) JUN 26 1995</p> <p>32. REGISTRAR'S SIGNATURE John Dawson-Robell</p>											



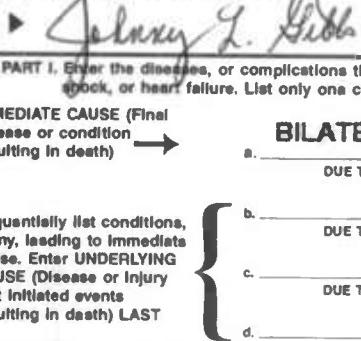
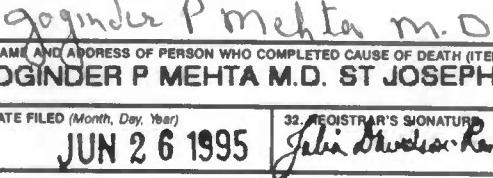
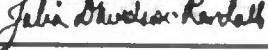
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH																	
		REG. NO. 95 19288																	
<p>1. DECEDENT'S NAME (First, Middle, Last) BERTHA SAXTON MILLER</p> <p>4. SOCIAL SECURITY NUMBER 215-14-6319 5. SEX M 6. AGE (In yrs. last birthday) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.</p> <p>9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center</p> <p>9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland</p> <p>2. DATE OF DEATH MONTH JUN DAY 19 YEAR 1995</p> <p>3. TIME OF DEATH 10:15 pm</p> <p>7. DATE OF BIRTHN (Month, Day, Year) March 29, 1921</p> <p>8. BIRTHPLACE (State or Foreign Country) Maryland</p>																			
<p>9c. COUNTY OF DEATH Baltimore</p> <p>10. RESIDENCE OF DECEDENT</p> <p>10a. STATE Maryland 10b. COUNTY Baltimore 10c. CITY, TOWN OR LOCATION Dundalk 10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>10e. STREET AND NUMBER 1911 Hazelmere Road 10f. ZIP CODE 21222 10g. CITIZEN OF WHAT COUNTRY? United States</p>																			
<p>11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</p>			<p>12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES</p>			<p>13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White</p>			<p>14. RACE — American Indian, Black, White, etc. Specify:</p>										
<p>15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) 11 Years College (1-4 or 5+) </p>			<p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress</p>			<p>16b. KIND OF BUSINESS/INDUSTRY Upholstery</p>													
<p>17. FATHER'S NAME (First, Middle, Last) Chester Lashley</p>						<p>18. MOTHER'S NAME (First, Middle, Maiden Surname) Hilda Witt</p>													
<p>19a. INFORMANT'S NAME (Type/Print) Mr. Hilton D. Miller</p>						<p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1911 Hazelmere Road Dundalk, Maryland 21222</p>													
<p>20a. METHOD OF DISPOSITION Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)</p>			<p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Mem. Gdns</p>			<p>DATE 6/23/95</p>			<p>20c. LOCATION — City or Town, State Middle River, MD</p>										
<p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE </p>						<p>22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222</p>													
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → BILATERAL PNEUMONIA</p> <p>a. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Approximate Interval Between Onset and Death 1 MONTH</p>																			
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE CORONARY ARTERY DISEASE</p>						<p>24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p>			<p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p>										
<p>25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> NO</p>			<p>26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</p>																
<p>27. MANNER OF DEATH</p> <table border="0"> <tr> <td>1 <input type="checkbox"/> Natural</td> <td>5 <input type="checkbox"/> Pending investigation</td> </tr> <tr> <td>2 <input type="checkbox"/> Accident</td> <td></td> </tr> <tr> <td>3 <input type="checkbox"/> Suicide</td> <td>8 <input type="checkbox"/> Could not be determined</td> </tr> <tr> <td>4 <input type="checkbox"/> Homicide</td> <td></td> </tr> </table>			1 <input type="checkbox"/> Natural	5 <input type="checkbox"/> Pending investigation	2 <input type="checkbox"/> Accident		3 <input type="checkbox"/> Suicide	8 <input type="checkbox"/> Could not be determined	4 <input type="checkbox"/> Homicide		<p>28a. DATE OF INJURY (Month, Day, Year)</p>			<p>28b. TIME OF INJURY M</p>			<p>28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</p>		
1 <input type="checkbox"/> Natural	5 <input type="checkbox"/> Pending investigation																		
2 <input type="checkbox"/> Accident																			
3 <input type="checkbox"/> Suicide	8 <input type="checkbox"/> Could not be determined																		
4 <input type="checkbox"/> Homicide																			
			<p>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</p>						<p>28d. DESCRIBE NOW INJURY OCCURED</p>										
									<p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p>										
<p>29a. CERTIFIER (Check only one)</p>			<p>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p>																
<p>29b. SIGNATURE AND TITLE OF CERTIFIER </p>						<p>29c. LICENSE NUMBER D41410</p>			<p>29d. DATE SIGNED (Month, Day, Year) ► 06-19-95</p>										
<p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JOGINDER P MEHTA M.D. ST JOSEPH MEDICAL CENTER, TOWSON, MARYLAND 21204</p>																			
<p>31. DATE FILED (Month, Day, Year) JUN 26 1995</p>			<p>32. REGISTRAR'S SIGNATURE </p>																

100% FINEST COTTON 100% POLYESTER

100% POLYESTER

ADVANTAGES

DRY CLEAN
WASHABLE

100% COTTON FABRIC - 100% POLYESTER - 100% POLYESTER
100% POLYESTER

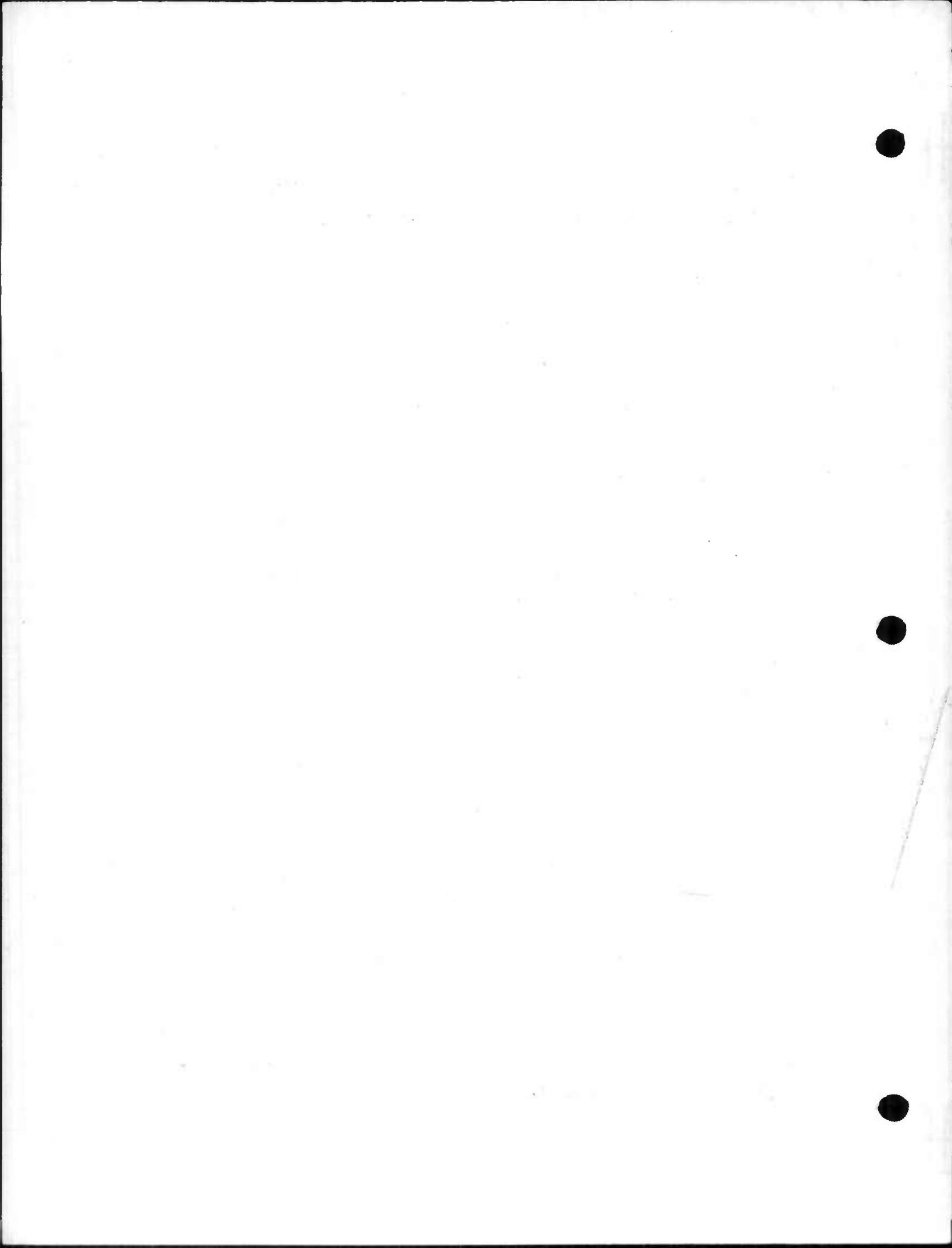
ITEMS: 23 PART I, 27, PER MEO FILM G-725 7/27/95 t.t.

95 19289

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		OSKAY		2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
PARISH I 4. SOCIAL SECURITY NUMBER 218-39-9240		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN.	JUNE 17, 1995 6:25 A.M.	
9a. FACILITY NAME (If not institution, give street and number) SAINT AGNES HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		7. DATE OF BIRTH (Month, Day, Year) August 24, 1993	
RESIDENCE OF DECEDENT		10c. CITY, TOWN OR LOCATION Catonsville		8. BIRTHPLACE (State or Foreign Country) Ms	
10a. STATE Md	10b. COUNTY Baltimore	10e. STREET AND NUMBER 23 Merrill Rd		10f. ZIP CODE 21228	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) N/A		16b. KIND OF BUSINESS/INDUSTRY N/A	
17. FATHER'S NAME (First, Middle, Last) Jason Oskay		18. MOTHER'S NAME (First, Middle, Maiden Surname) Adrienne McGill			
19a. INFORMANT'S NAME (Type/Print) Jason Oskay		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 23 Merrill Rd Catonsville, Md. 21228		20c. LOCATION — City or Town, State Owning Mills, Md.	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Garrison forest		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE 6-21-95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kala Marsh		22. NAME AND ADDRESS OF FACILITY March funeral Home - West 4300 Wabash Ave.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → VARICELLA (CHICKENPOX) WITH COMPLICATIONS					
Approximate Interval Between Onset and Death					
24. NAME AND ADDRESS OF FACILITY March funeral Home - West 4300 Wabash Ave.					
25. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined					
28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD					
29c. LICENSE NUMBER O.C.M.E					
29d. DATE SIGNED (Month, Day, Year) JUNE 18, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD					
31. DATE FILED (Month, Day, Year) JUN 26 1995					
32. REGISTRAR'S SIGNATURE Jane Anderson Harrell					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

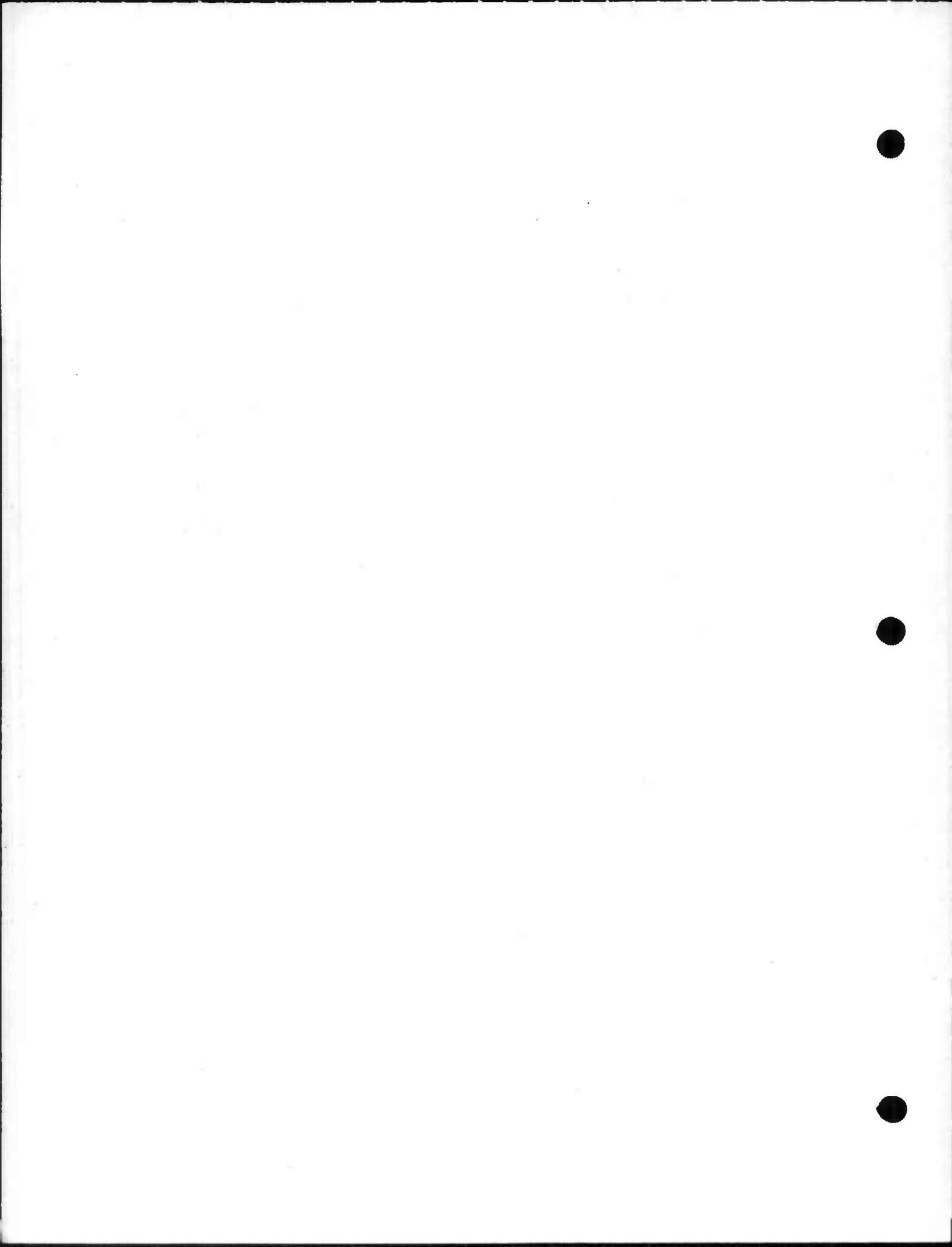
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19290

1. DECEDENT'S NAME (First, Middle, Last) GERTRUDE ANNE OLIVER						2. DATE OF DEATH MONTH JUNE DAY 21, 1995 YEAR	3. TIME OF DEATH 10:50 P M
4. SOCIAL SECURITY NUMBER 216-28-9640		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) APR. 19, 1927	8. BIRTHPLACE (State or Foreign Country) VIRGINIA
9a. FACILITY NAME (If not institution, give street and number) 837 N. PATTERSON PARK				9b. CITY, TOWN OR LOCATION OF DEATH AVENUE - BALTIMORE CITY		9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND	10b. COUNTY n/a	10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 837 N. PATTERSON PARK				10f. ZIP CODE 21205		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — It yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) —			16b. KIND OF BUSINESS/INDUSTRY POMPEI OLIVE OIL COMPANY		
17. FATHER'S NAME (First, Middle, Last) MALACHI LOFLAND				18. MOTHER'S NAME (First, Middle, Maiden Surname) LUVENIA MARTIN			
19a. INFORMANT'S NAME (Type/Print) MALACHI LOFLAND				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5409 MOORES RUN DRIVE, BALTIMORE, MD 21206			
20a. METHOD OF DISPOSITION X <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) —				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CHELTENHAM VA CEMETERY		DATE 6-26	20c. LOCATION — City or Town, State CHELTENHAM, MARYLAND
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James L. Chapman</i>				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE			
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (First disease or condition resulting in death) → a. <i>Melanoma Lung Cancer</i> DUE TO (DR AS A CONSEQUENCE OF):							
b. DUE TO (DR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerry Waterbury, M.D.</i>				29c. LICENSE NUMBER DO 9559		29d. DATE SIGNED (Month, Day, Year) ► 6/23/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LARRY WATERBURY, M.D. 4940 EASTERN, BALT., MD. 21224							
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. APPROVED FOR TRANSMISSION <i>Jahn</i>					

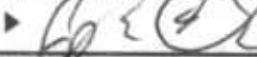


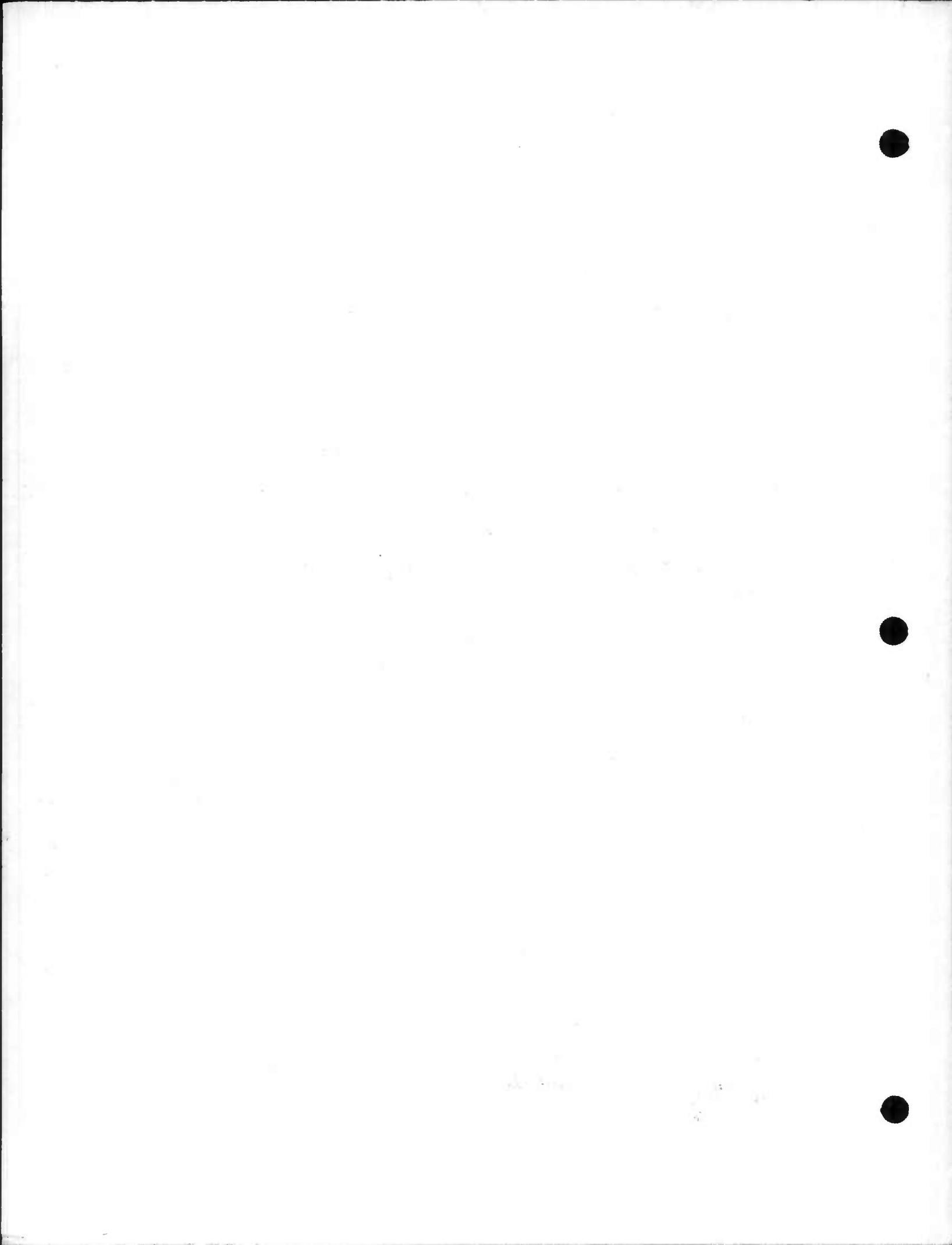
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
MARTIN PATRICK O'DONNELL										JUNE 23 1995	4:45 a.m.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
218186306		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	74 YRS.			DEC 24, 1920		MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) 1102 CHESACO AVENUE										9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE	9c. COUNTY OF DEATH BALTIMORE
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1102 CHESACO AVENUE					10f. ZIP CODE 21237			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) FIRE FIGHTER			16b. KIND OF BUSINESS/INDUSTRY FIRE FIGHTING						
17. FATHER'S NAME (First, Middle, Last) JOSEPH O'DONNELL					18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA K. CRIST						
19a. INFORMANT'S NAME (Type/Print) ROSE M. O'DONNELL					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1102 CHESACO AVE ROSEDALE, MD 21237						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): GARDENS OF FAITH					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH			DATE 6/26	20c. LOCATION — City or Town, State BALTIMORE, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE BALTIMORE, MD 21237						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. lung cancer b. metastatic to liver c. d.										Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Wendy Weiss, D.O.					29c. LICENSE NUMBER AF2324412-1670			29d. DATE SIGNED (Month, Day, Year) 06/23/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WENDY WEISS 9000 FRANKLIN SQUARE DR. BALTO, MD. 21237											
31. DATE FILED (Month, Day, Year) JUN 26 1995					32. REGISTRATION NUMBER John A. Weis						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

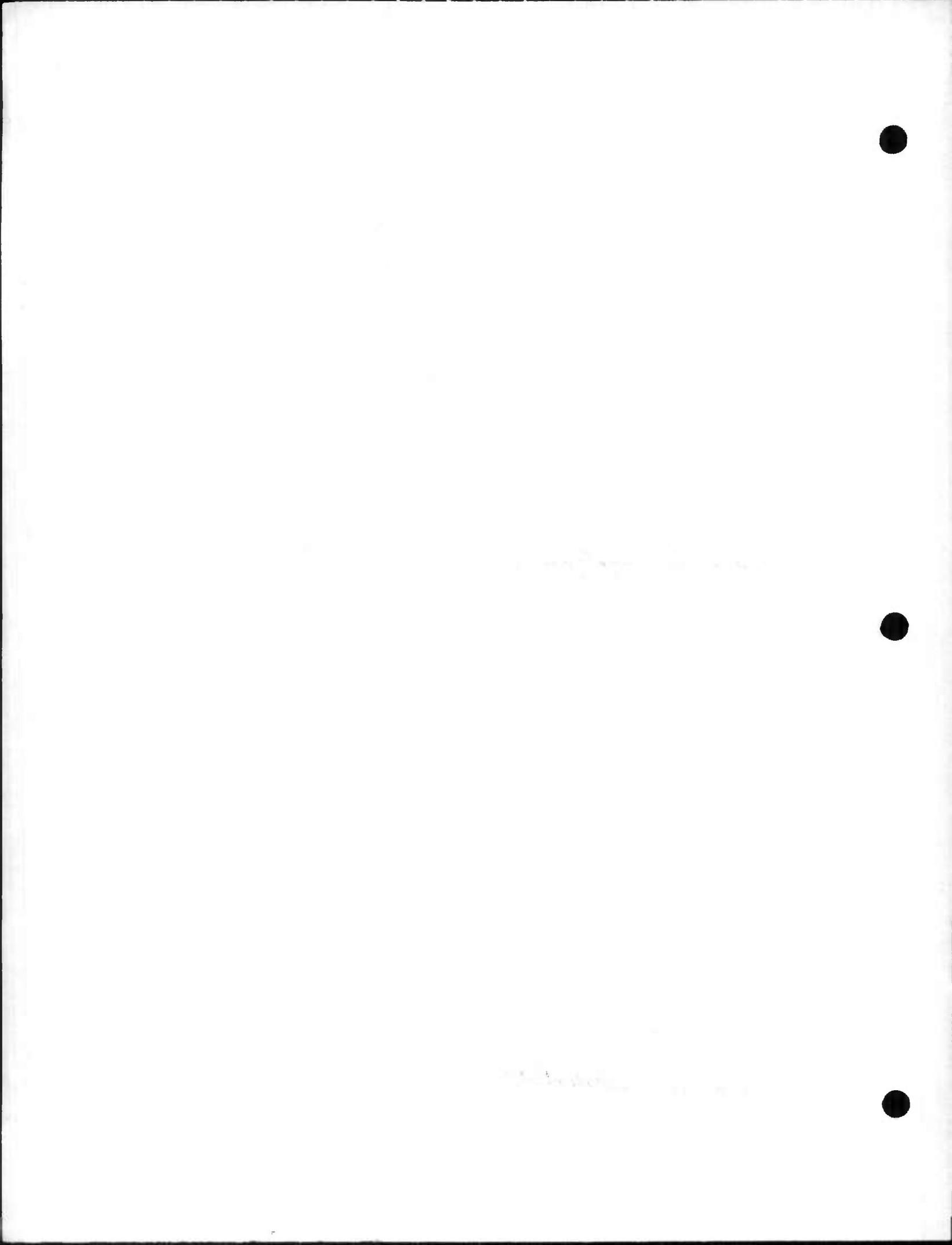
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 24 1995								3. TIME OF DEATH 12:00 PM	
1. DECEDENT'S NAME (First, Middle, Last) Turaman Persaud										7. DATE OF BIRTH (Month, Day, Year) April 17, 1931	8. BIRTHPLACE (State or Foreign Country) Guiana
4. SOCIAL SECURITY NUMBER 215-11-2905		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number) Riverview Nursing Centre, Inc.										9b. CITY, TOWN OR LOCATION OF DEATH Essex	9c. COUNTY OF DEATH Baltimore
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Essex								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4 B Glenwood Road										10f. ZIP CODE 21221	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. East Indian	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance				16b. KIND OF BUSINESS/INDUSTRY Restaurant					
17. FATHER'S NAME (First, Middle, Last) Ramsundar										18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown	
19a. INFORMANT'S NAME (Type/Print) Pooters Harme Persaud										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1031 Debbie Ave. Balt. MD. 21221	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory				DATE 6/26/1995		20c. LOCATION — City or Town, State Baltimore MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A.									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →								Approximate Interval Between Onset and Death years			
a. Chronic Obstructive Lung Disease DUE TO (OR AS A CONSEQUENCE OF):											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D44604				29d. DATE SIGNED (Month, Day, Year) ► 6/24/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Michael Suter Franklin Square Hospital Baltimore, Maryland 21237											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRATION SIGNATURE 								DHMH-16 Rev 1/B9	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

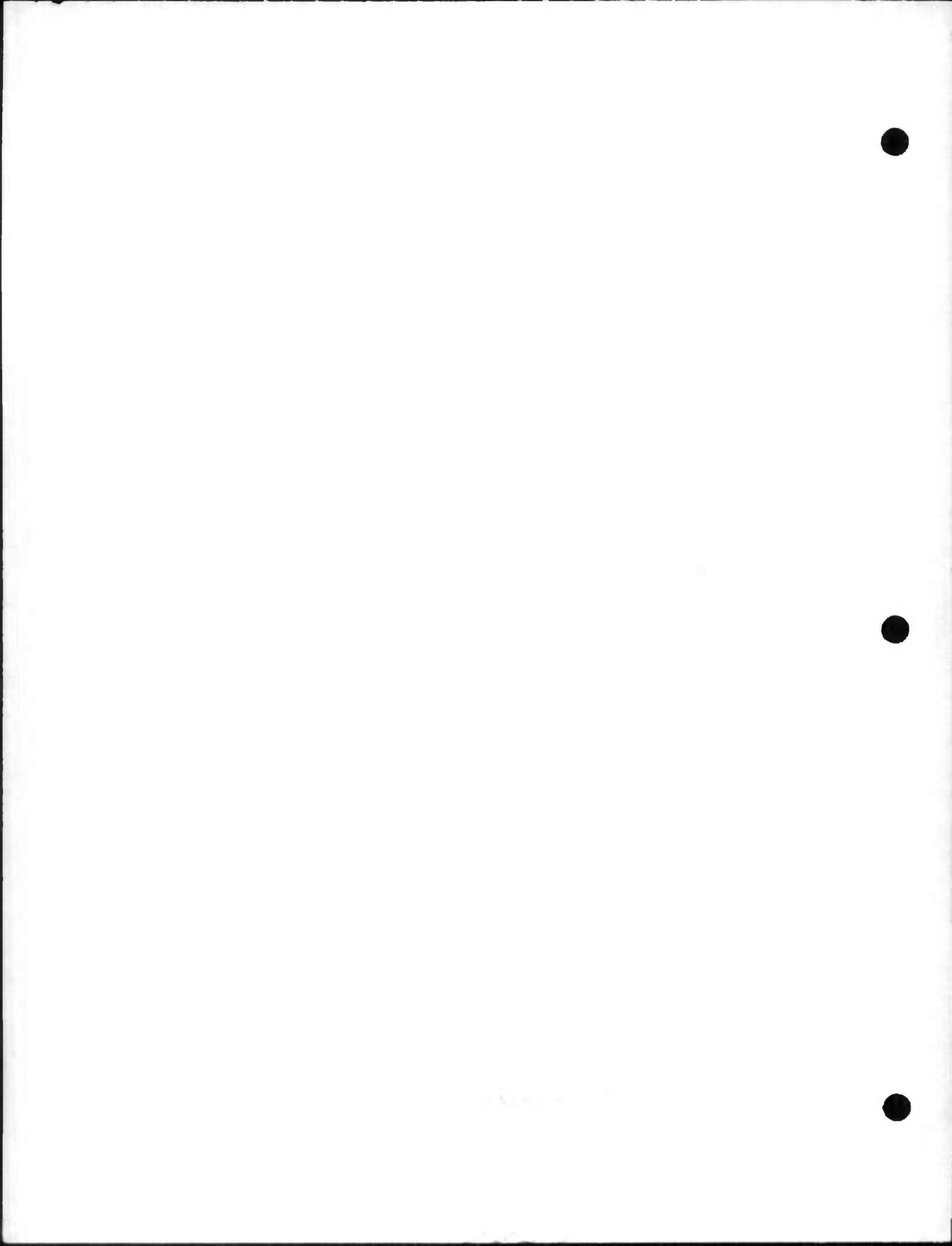
TO BE COMPLETED BY FUNERAL DIRECTOR

95 19293

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Harod W. Phillips						2. DATE OF DEATH MONTH DAY YEAR June 25, 1995	3. TIME OF DEATH 10:30 A.M.	
4. SOCIAL SECURITY NUMBER 248-32-2283		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7. DATE OF BIRTH (Month, Day, Year) Oct 1, 1914	8. BIRTHPLACE (State or Foreign Country) South Carolina	
9a. FACILITY NAME (If not institution, give street and number) 307 14th Ave			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Anne Arundel		
RESIDENCE OF DECEDENT								
10a. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 307 14th Ave			10f. ZIP CODE 21225			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 8th Grade			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automobile Painter			16b. KIND OF BUSINESS/INDUSTRY Automobile Painting			
17. FATHER'S NAME (First, Middle, Last) William T. Phillips				18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Watts				
19a. INFORMANT'S NAME (Type/Print) Verdia I. Phillips				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 307 14th Ave, Baltimore, Maryland 21225				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery			DATE 6/28	20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Davis				22. NAME AND ADDRESS OF FACILITY Gonce Funeral Home 4001 Ritchie Highway, Balto, Md 21225				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
<p>a. ACUTE LEUKEMIA DUE TO (OR AS A CONSEQUENCE OF): SIDENOBLASTIC ANEMIA</p> <p>b. LIVER CIRRHOSIS DUE TO (OR AS A CONSEQUENCE OF): HOSICO</p>								
Approximate Interval Between Onset and Death								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D18426						
29b. SIGNATURE AND TITLE OF CERTIFIER Paolo M. Palatnik		29d. DATE SIGNED (Month, Day, Year) ► 6-26-96						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 903 E. PATAPSCO AVENUE BALTIMORE MD 21225		32. REGISTRAR'S SIGNATURE John Shuler						
31. DATE FILED (Month, Day, Year) JUN 26 1995								



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

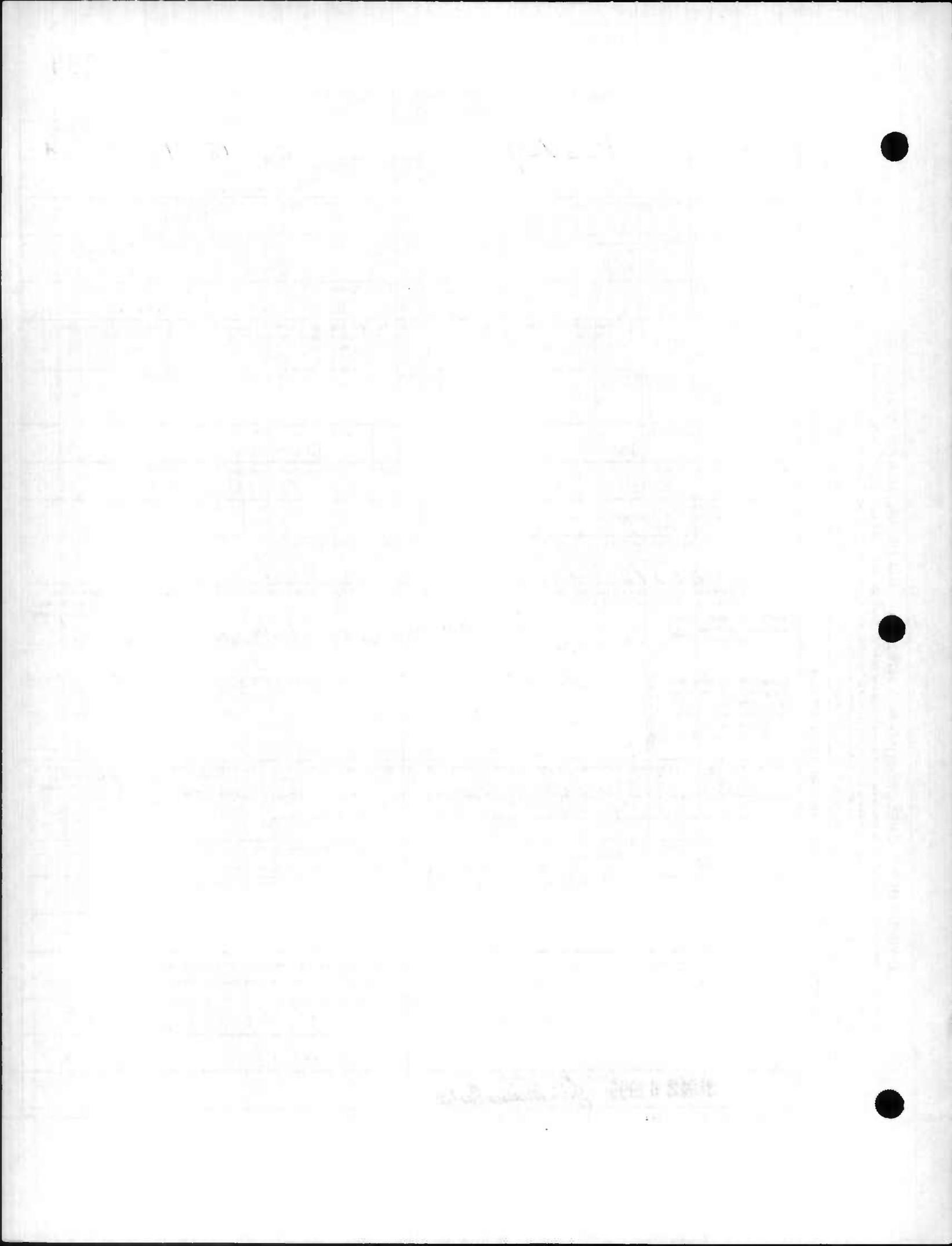
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.									
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR 06 18 95								3. TIME OF DEATH 3:35 A.M.									
1. DECEDENT'S NAME (First, Middle, Last) FRANCES Peevey										7. DATE OF BIRTH (Month, Day, Year) Feb. 12, 1925									
4. SOCIAL SECURITY NUMBER 218 18 9298		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Maryland									
9a. FACILITY NAME (If not institution, give street and number) North Arundel Convalescent Home										9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie									
9c. COUNTY OF DEATH Anne Arundel																			
RESIDENCE OF DECEDENT																			
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER North Arundel Convalescent Home 313 Hospital Drive										10f. ZIP CODE 21061		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary								16b. KIND OF BUSINESS/INDUSTRY Maryland Paper Box Company							
17. FATHER'S NAME (First, Middle, Last) Joseph Marmor										18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth Hall									
19a. INFORMANT'S NAME (Type/Print) Bernetta Crislip					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 554 - 2nd Street Gambrills, Maryland 21054														
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park							DATE 6/21	20c. LOCATION — City or Town, State Glen Burnie, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>George J. Goncze</i>												22. NAME AND ADDRESS OF FACILITY George J. Goncze Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Approximate Interval Between Onset and Death							
a. <i>probable cardiac arrhythmia</i> minutes DUE TO (OR AS A CONSEQUENCE OF):																			
b. <i>Coronary artery disease</i> days DUE TO (OR AS A CONSEQUENCE OF):																			
c. <i></i> minutes DUE TO (OR AS A CONSEQUENCE OF):																			
d. <i></i> days DUE TO (OR AS A CONSEQUENCE OF):																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Perc. of tracheobronchomalacia aspiration pneumonia</i>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <table border="0"><tr><td><input type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td></td></tr><tr><td><input type="checkbox"/> Suicide</td><td><input type="checkbox"/> Could not be determined</td></tr><tr><td><input type="checkbox"/> Homicide</td><td></td></tr></table>		<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED			
<input type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																		
<input type="checkbox"/> Accident																			
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																		
<input type="checkbox"/> Homicide																			
		28a. PLACE OF INJURY — At home, farm, street, factory, office <i>At home</i>						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>At home</i>											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>George J. Goncze</i>																	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>George J. Goncze</i>		32. REGISTRAR'S SIGNATURE <i>Jeanne M. Bannister</i>		31. DATE FILED (Month, Day, Year) June 6 1995		33. LICENSE NUMBER 029767		29d. DATE SIGNED (Month, Day, Year) 6/18/95											



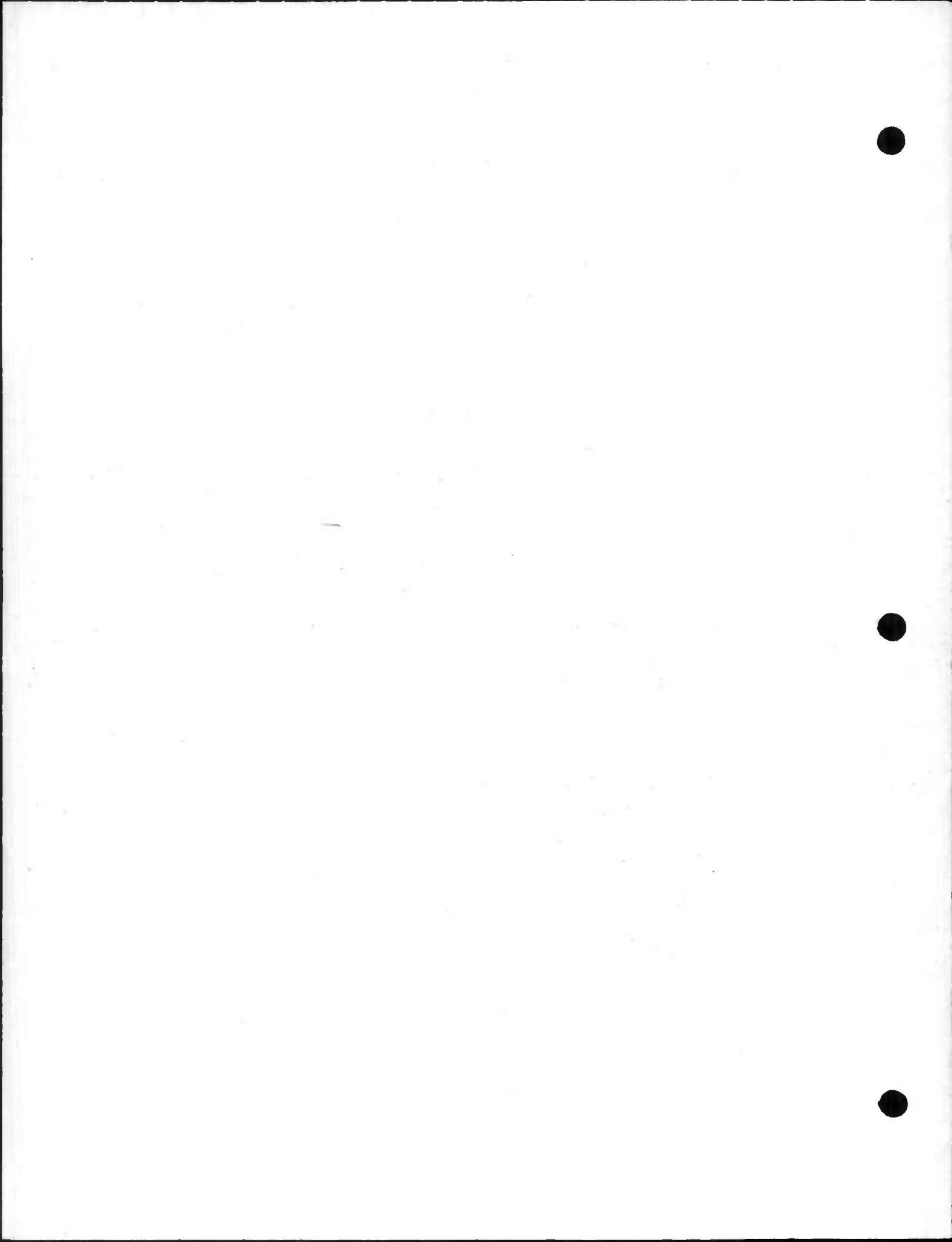
95 19295

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		Catherine Mary Plantholt				2. DATE OF DEATH MONTH JUNE DAY 23, 1995 YEAR	3. TIME OF DEATH 6:30 a.m.	
4. SOCIAL SECURITY NUMBER 218-09-2643		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct 19 1918		8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) St. Joseph Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Towson				9c. COUNTY OF DEATH Baltimore Co.		
RESIDENCE OF DECEDENT								
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Parkville				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 8304 Beryl Road			10f. ZIP CODE 21234			10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Bernard H. Maas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary B. Habberkorn				
19a. INFORMANT'S NAME (Type/Print) Mr. Charles B. Plantholt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8303 Oakleigh Rd. Baltimore, Md. 21234				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, if known, or other place) Parkwood Cemetery			26	DATE 6/23/95	20c. LOCATION — City or Town, State Parkville, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark T. Zavoyna</i>		22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Maryland 21214						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
<p>a. <i>Proxemicaria</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Sens CO PD</i></p> <p>b. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p> <p>Approximate Interval Between Onset and Death <i>days years</i></p>								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cerebral Hemorrhage</i> <i>Hypertension</i>								
<p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/></p> <p>24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Determined <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Gracito Patricio, M.D.</i>		29c. LICENSE NUMBER <i>008758</i>		29d. DATE SIGNED (Month, Day, Year) ► June 23, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gracito Patricio, M.D. 8903 Harford Road Parkville, Maryland 21234		31. DATE FILED (Month, Day, Year) <i>JUN 26 1995</i>						
32. REGISTRAR'S SIGNATURE <i>Jahn Shuler-Randall</i>								



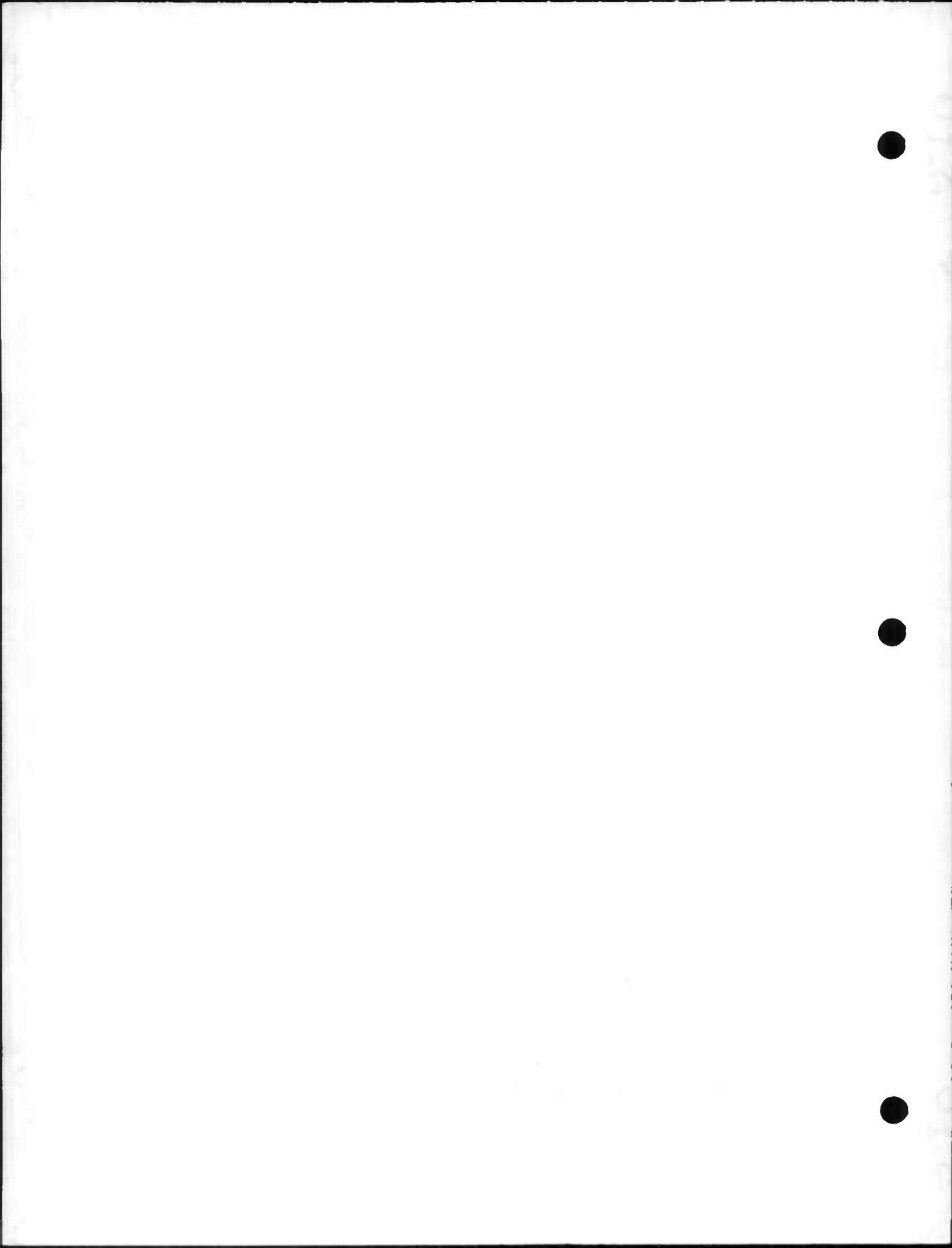
DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - STATE REGISTRAR																		
1. DECEDENT'S NAME (First, Middle, Last)													2. DATE OF DEATH		3. TIME OF DEATH			
LEROY CUNNINGHAM PINKNEY													JUNE 16 1995		P.M. 1:15			
4. SOCIAL SECURITY NUMBER			5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		MONTH DAY YEAR		8. BIRTHPLACE (State or Foreign Country)					
128-14-6440			<input checked="" type="checkbox"/> M <input type="checkbox"/> F		72 YRS.		MONTHS		DAYS		HOURS MIN.		MAR. 5, 1923 SOUTH CAROLINA					
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH												9c. COUNTY OF DEATH			
535 N. CAREY STREET			BALTIMORE												N/A			
RESIDENCE OF DECEDENT																		
10a. STATE			10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?											
MARYLAND			N/A		BALTIMORE		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO											
10e. STREET AND NUMBER			10f. ZIP CODE												10g. CITIZEN OF WHAT COUNTRY?			
535 N. CAREY STREET			21223												U.S.A.			
11. MARITAL STATUS			12. WAS DECEDENT EVER IN U.S. ARMED FORCES?			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. RACE — American Indian, Black, White, etc. Specify:									
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married			1 <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			BLACK									
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			5-26-43/2-8-46															
15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY												
Elementary/Secondary (0-12) 8TH GRADE			College (14 or 5+)			CRANE OPERATOR			BETHLEHEM STEEL CORP.									
17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Maiden Surname)															
LEROY CUNNINGHAM			MATTIE (MN-UNKNOWN)															
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)															
NORMA ROSE CUNNINGHAM			535 N. CAREY ST., BALTIMORE, MD. 21223															
20a. METHOD OF DISPOSITION			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. LOCATION — City or Town, State												
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State			GARRISON FOREST CEME. 623-95 O'WINGS MILLS, MD.															
4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)																		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE			22. NAME AND ADDRESS OF FACILITY															
► Brown			JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTIMORE ST., BALTIMORE, MD. 21223															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																		
a. ADENOCARCINOMA PROSTATE DUE TO (OR AS A CONSEQUENCE OF):																		
b. BONE METASTASIS DUE TO (OR AS A CONSEQUENCE OF):																		
c. DUE TO (OR AS A CONSEQUENCE OF):																		
d. DUE TO (OR AS A CONSEQUENCE OF):																		
Approximate Interval Between Onset and Death 8 MONTHS																		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?			26. PLACE OF DEATH (Check only one)			24a. WAS AN AUTOPSY PERFORMED?			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?									
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			<input type="checkbox"/> YES <input type="checkbox"/> NO									
27. MANNER OF DEATH			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED						
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one)			1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. SIGNATURE AND TITLE OF CERTIFIER Victor Salama MD			29c. LICENSE NUMBER DO 4805			29d. DATE SIGNED (Month, Day, Year) ► 6/20/95												
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)																		
VICTOR SALAMA MD 1940 W. BALTIMORE ST. BALTIMORE, MD 21223																		
31. DATE FILED (Month, Day, Year)			32. REGISTRAR'S SIGNATURE Julie A. Kudler-Randall															
JUN 26 1995																		



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

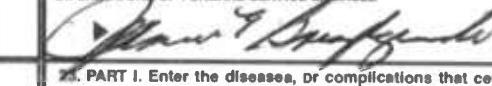
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

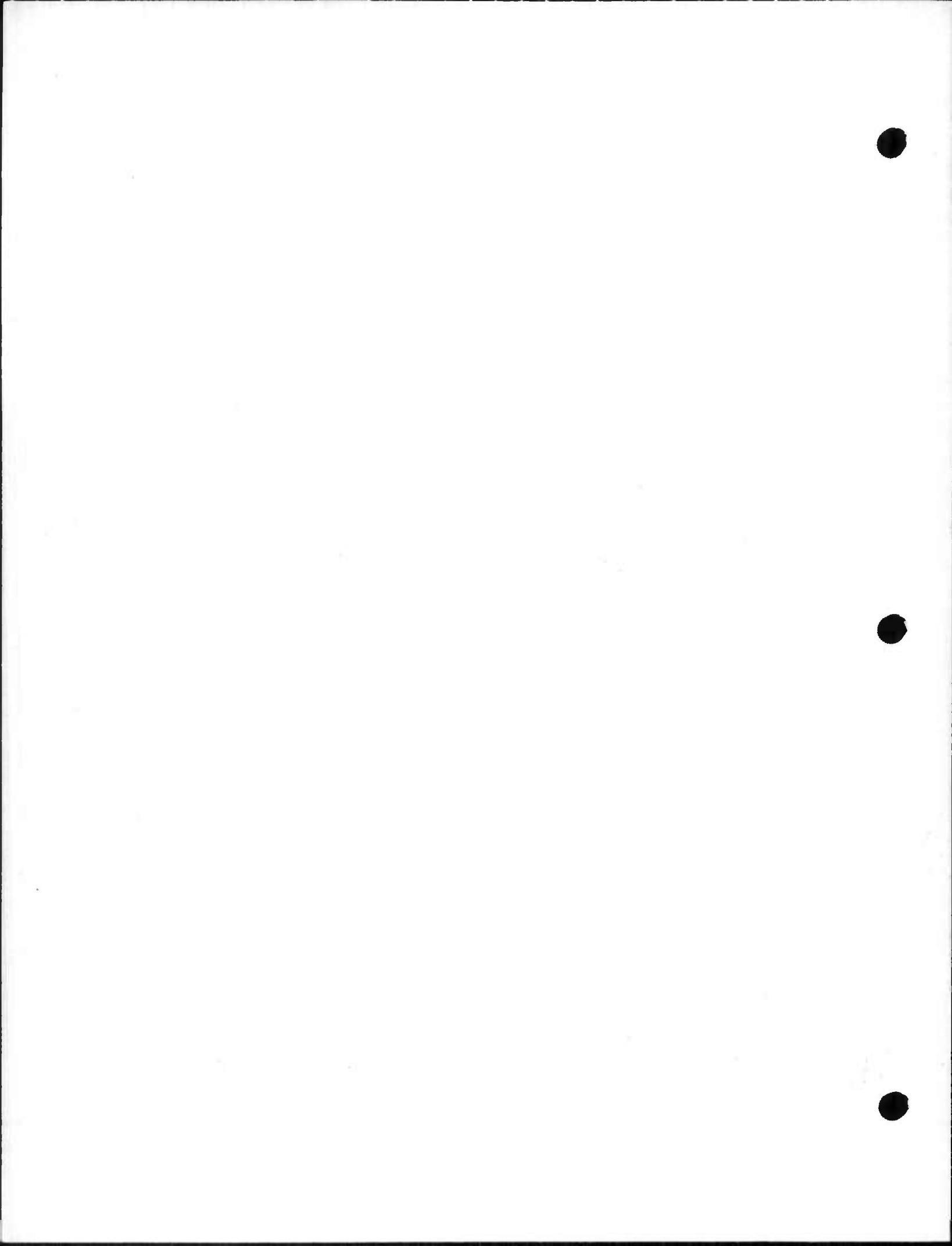
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR												95 19297
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Hiram RIFFE											June 23, 1995	10:00 a.m.
4. SOCIAL SECURITY NUMBER 235-28-6179		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year) Dec, 14, 1921			9. BIRTHPLACE (State or Foreign Country) W. Virginia	
8a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Rossville										9c. COUNTY OF DEATH Baltimore Baltimore County
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Middle River										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 200 Middleway Road Apt. 1 B											10f. ZIP CODE 21220	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR DR. DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman		16b. KIND OF BUSINESS/INDUSTRY Food Products								
17. FATHER'S NAME (First, Middle, Last) Elmer Riffe											18. MOTHER'S NAME (First, Middle, Maiden Surname) Addie Kitchen	
19a. INFORMANT'S NAME (Type/Print) Anna M. Riffe					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Middleway Rd. Apt. 1 B Balt. MD. 21220							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crest Lawn Cemetery			DATE 6/26/1995		20c. LOCATION — City or Town, State Howard County MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A. 1407 Eastern Ave. Balt. MD. 21221										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. Hepatic Coma DUE TO (OR AS A CONSEQUENCE OF):											7 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. Cirrhosis of Liver DUE TO (OR AS A CONSEQUENCE OF): d. Hepatitis C DUE TO (OR AS A CONSEQUENCE OF):											3 years 4 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Insulin Dependent Diabetes Mellitus Arteriosclerotic Heart Disease DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Investigation 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D17728		29d. DATE SIGNED (Month, Day, Year) ► 6-23-95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ba Yin Oung, M.D. 8022 Belair Road Baltimore, Maryland 21236												
31. DATE FILED (Month, Day, Year) JUN 26 1995		Julia [Signature]										



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

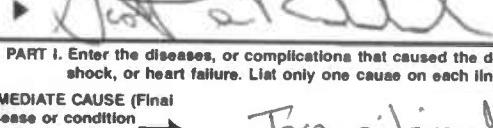
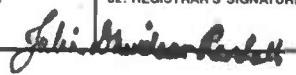
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

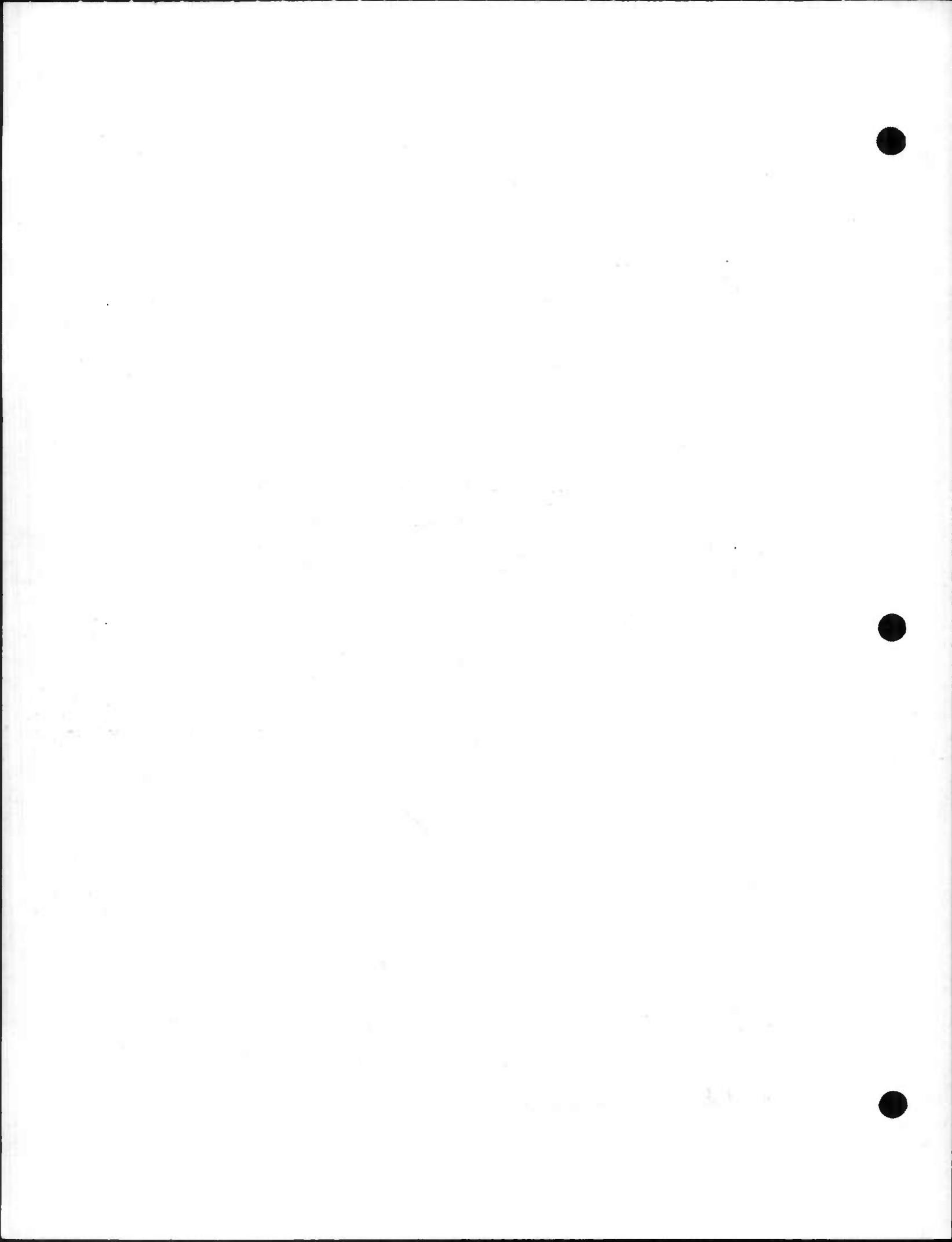
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) HARRIET A. REDMOND										2. DATE OF DEATH MONTH DAY YEAR JUNE 26 1995	3. TIME OF DEATH 9:50A
4. SOCIAL SECURITY NUMBER 219-28-4863		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JULY 22, 1931		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	9c. COUNTY OF DEATH BALTIMORE CITY
RESIDENCE OF DECEDENT											
10a. STATE MARYLAND	10b. COUNTY ANNE ARUNDEL			10c. CITY, TOWN OR LOCATION GLEN BURNIE						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 103 WILSON BLVD.					10f. ZIP CODE 21061			10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: WHITE			14. RACE — American Indian, Black, White, etc. Specify:			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TOLL COLLECTOR			16b. KIND OF BUSINESS/INDUSTRY STATE GOVERNMENT						
17. FATHER'S NAME (First, Middle, Last) WALTER HIGGINS					18. MOTHER'S NAME (First, Middle, Maiden Surname) VIOLET GIBSON						
19a. INFORMANT'S NAME (Type/Print) JERRY L. STAMER					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 WILSON BLVD., GLEN BURNIE, MARYLAND 21061						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) GLEN HAVEN MEM. PK.		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Cemetery or other place) GLEN HAVEN MEM. PK., JUNE 28, '95			DATE JUNE 28, '95		20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY KIRKLEY-RUDDICK FUNERAL HOME 421 CRAIN HWY., S.E., GLEN BURNIE, MD 21061						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Transitional Cell Carcinoma of the Bladder with brain metastasis</i> ~3yrs.										Approximate Interval Between Onset and Death	
b. _____ c. _____ d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) JUNE 26, 1995		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? At home, farm, street, factory, office		28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home, farm, street, factory, office			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) HARBOR HOSPITAL CENTER 3001 SOUTH RANDY RD. BALTIMORE, MARYLAND 21225
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER AS2441614-22									
29d. DATE SIGNED (Month, Day, Year) JUNE 26, 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARY JUDYLINE J. MINGUETTO, M.D.											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

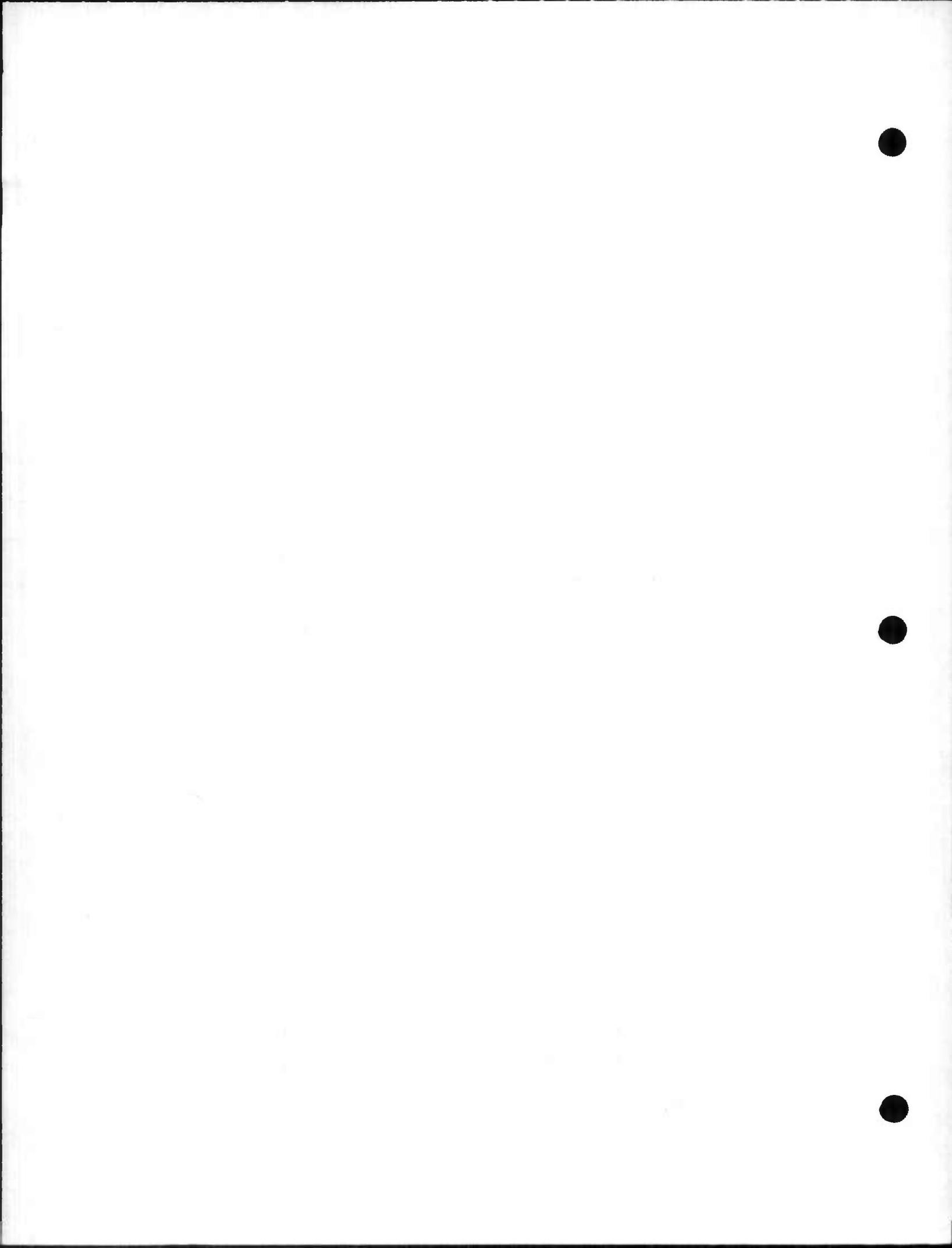
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19299

1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH 11:50 p.m.			
Charles Albert Rhode				June 20 1995							
4. SOCIAL SECURITY NUMBER 220-09-4660		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 15, 1919		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Northwest Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown				9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEASED											
10a. STATE Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 6512 Parr Avenue				10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th Grade			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Painter			16b. KIND OF BUSINESS/INDUSTRY Delta Contractors					
17. FATHER'S NAME (First, Middle, Last) Charles Rhode				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ethel Murray							
19a. INFORMANT'S NAME (Type/Print) Kathy Harmon			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1426 Pope Creek Drive Hampstead, MD 21074								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify):			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Woodlawn Cemetery 6/23/95			DATE	20c. LOCATION — City or Town, State Baltimore, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd. Randallstown, MD 21133-4784							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. ACUTE RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF):											
b. UROSEPSIS DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D33333				29d. DATE SIGNED (Month, Day, Year) ► JUNE 20, '95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. NAVI MD, NTC, BALTO. MD 21133											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 									



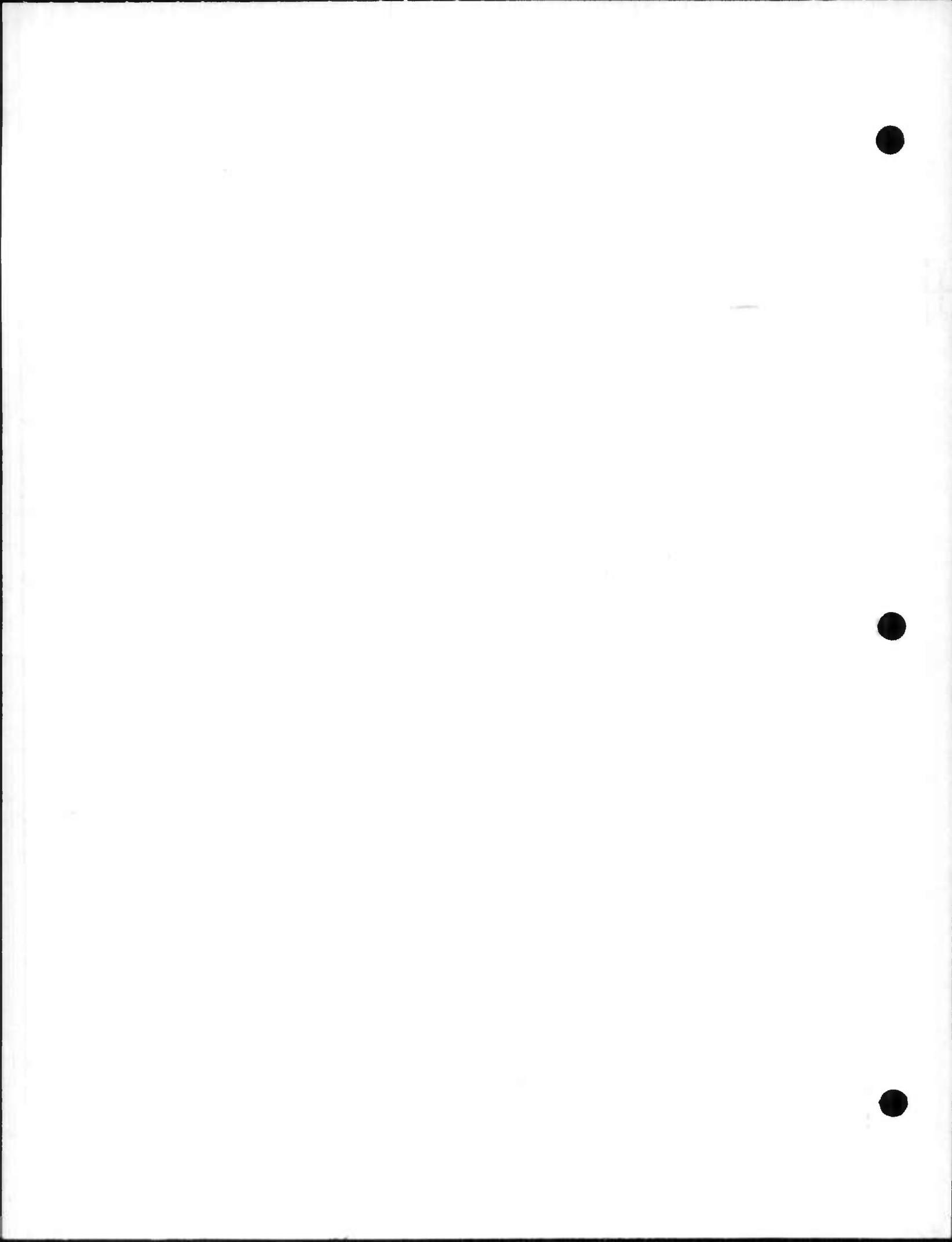
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH		3. TIME OF DEATH			
<i>Woodrow W. Rodgers, SR.</i>										MONTH DAY YEAR		5:03 A.M.			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
214-01-8423		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		77 YRS.		MONTHS		DAYS		(Month, Day, Year)		Maryland			
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH			
<i>North Arundel Hospital.</i>										<i>Glen Burnie</i>		<i>Anne Arundel</i>			
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?		10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
Maryland		Anne Arundel		Pasadena				<input checked="" type="checkbox"/>		681-618 213th St.		21122		U.S.A.	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>WWII</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <i>White</i>				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
1 Elementary/Secondary (0-12) 8		2 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Machinist</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Kennecott</i>					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)					
John H. Rodgers										<i>Clara C. Martin</i>					
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
<i>Jeannette McDevitt</i>										8328 Wicomico Rd. Pasadena, Md. 21122					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)				DATE		20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		Glen Haven Mem. Park				June 24, 95		Glen Burnie, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										22. NAME AND ADDRESS OF FACILITY					
<i>Jane Polynak</i>										<i>McCullly Funeral Home 3204 Mountain Rd. Pasadena, Md. 21122</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										<i>Massive Gastrointestinal bleed</i> Days					
DUE TO (OR AS A CONSEQUENCE OF): <i>Sepsis</i>										~ Weeks					
c. <i>Atrial Fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF):										Months					
d. <i>Renal failure</i>										?					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)													
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								OTHER:					
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)		1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER		Anas Mugharbi MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)						<i>D 44397</i>		<i>06/21/95</i>							
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE													
JUN 28 1995		<i>Julin D. Walker-Kardell</i>													



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

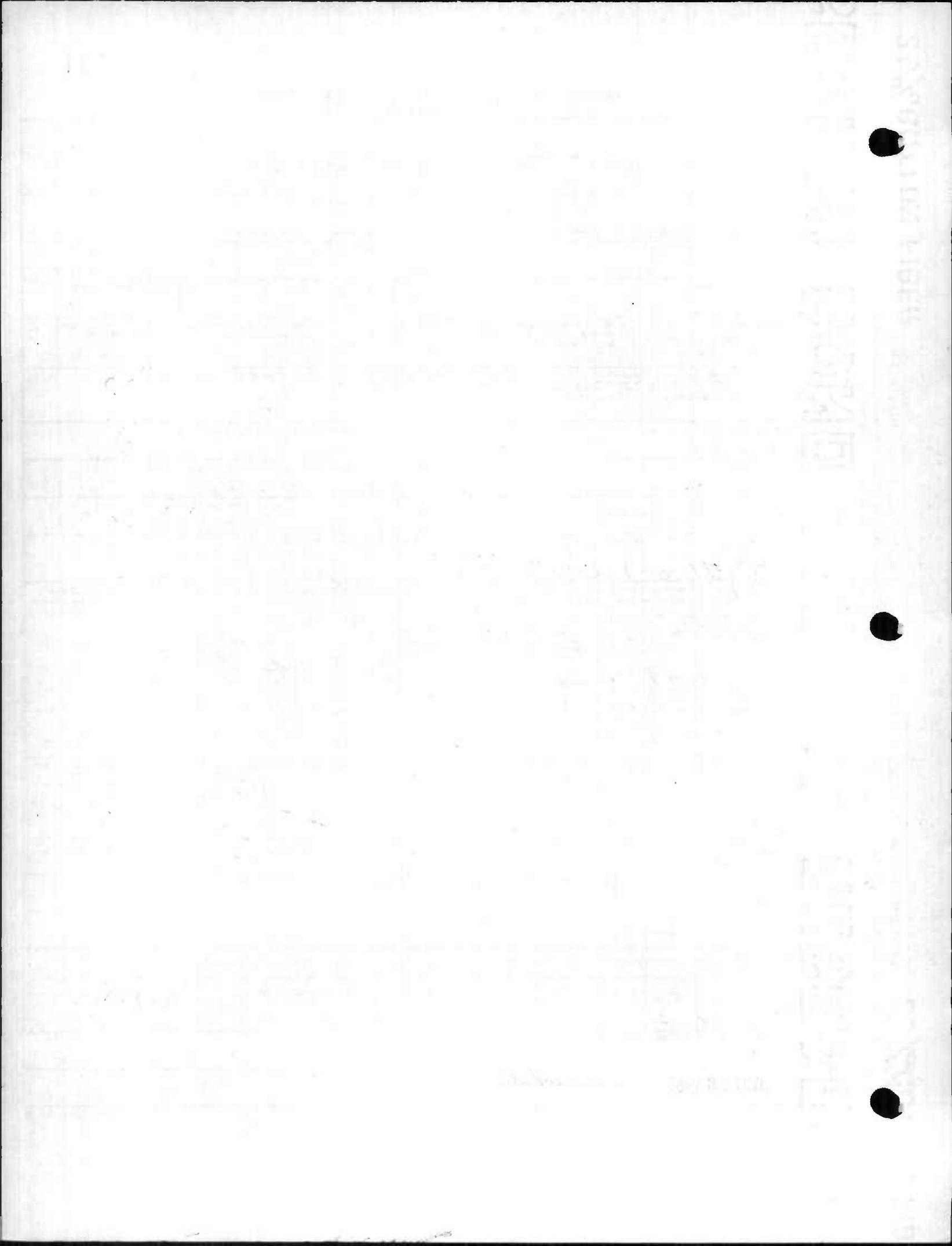
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19301

1. DECEDENT'S NAME (First, Middle, Last) <i>Ludwik Rynkowski</i>						2. DATE OF DEATH MONTH 6 DAY 22 YEAR 95	3. TIME OF DEATH 10:45 AM								
4. SOCIAL SECURITY NUMBER 214-16-8552		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) 8/27/1917	8. BIRTHPLACE (State or Foreign Country) Maryland								
9a. FACILITY NAME (If not institution, give street and number) Church Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH N/A									
RESIDENCE OF DECEDENT															
10a. STATE Maryland	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 X YES 2 □ NO									
10e. STREET AND NUMBER 402 S. Ann Street			10f. ZIP CODE 21231			10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify			14. RACE — American Indian, Black, White, etc. Specify: White								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Welder										
17. FATHER'S NAME (First, Middle, Last) Stanislaus Rynkowski			18. MOTHER'S NAME (First, Middle, Maiden Surname) Maria Kijewska												
19a. INFORMANT'S NAME (Type/Print) Wanda Rynkowski			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 402 S. Ann Street, Balto. Md. 21231												
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sc. Ht. of Mary Cemetery 6-26			DATE	20c. LOCATION — City or Town, State Baltimore, Md.								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen Weber CFSP</i>			22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 401 S. Chester St. Balto., Md. 21231												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
<p>a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. Malnutrition DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>															
Approximate Interval Between Onset and Death															
24. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO															
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO															
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 □ ER/Outpatient 3 □ DOA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)															
27. MANNER OF DEATH <table border="0"> <tr> <td>1 X Natural</td> <td>5 □ Pending investigation</td> </tr> <tr> <td>2 □ Accident</td> <td></td> </tr> <tr> <td>3 □ Suicide</td> <td>8 □ Could not be determined</td> </tr> <tr> <td>4 □ Homicide</td> <td></td> </tr> </table>								1 X Natural	5 □ Pending investigation	2 □ Accident		3 □ Suicide	8 □ Could not be determined	4 □ Homicide	
1 X Natural	5 □ Pending investigation														
2 □ Accident															
3 □ Suicide	8 □ Could not be determined														
4 □ Homicide															
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURRED											
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)															
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nina F. Everett</i>				29c. LICENSE NUMBER D46444		29d. DATE SIGNED (Month, Day, Year) 6/22/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) NINA F. EVERETT MD 2323 Orleans St, Baltimore Md 21227															
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Jane Anne Rader</i>													



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

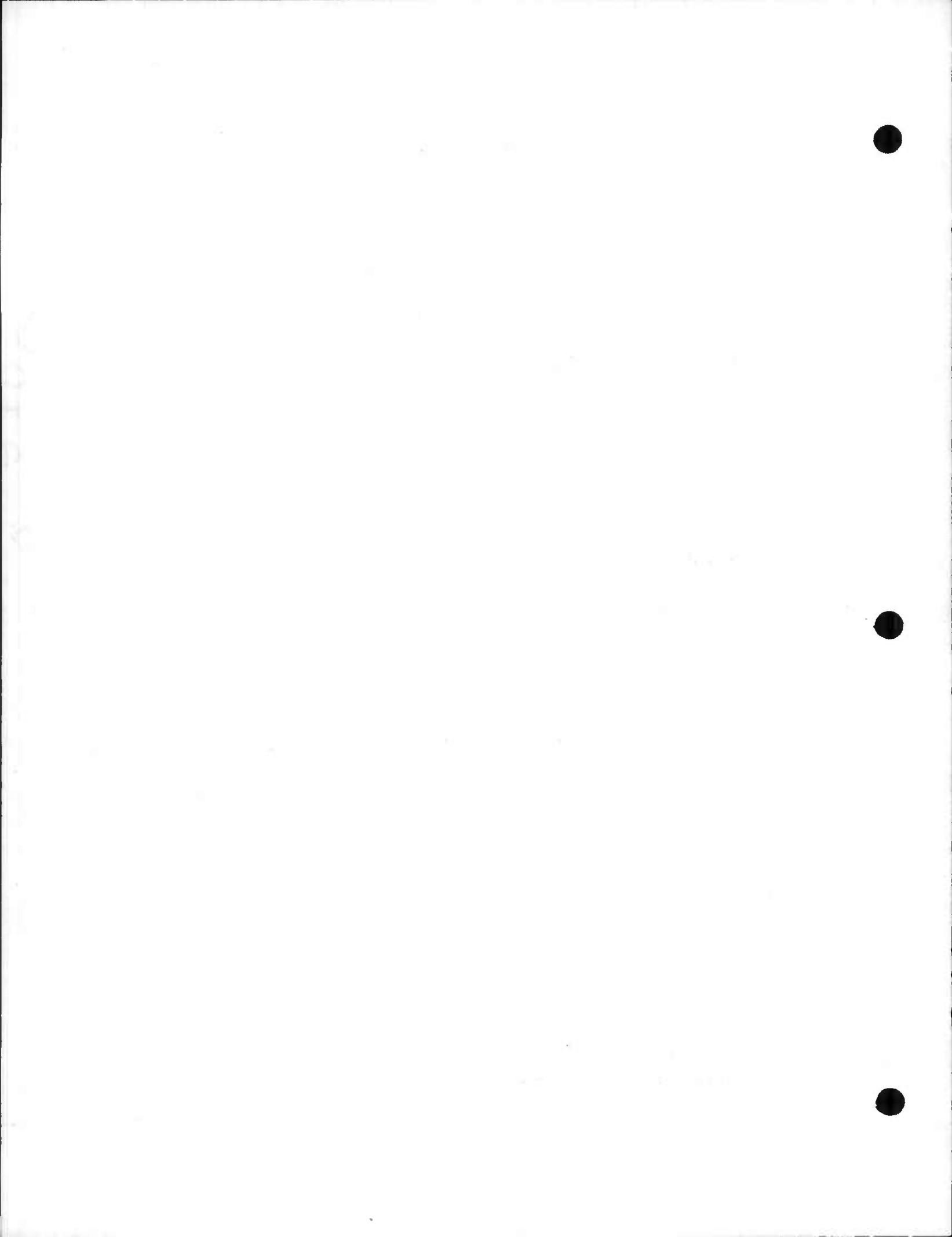
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19302

1. DECEDENT'S NAME (First, Middle, Last) ROBERT HARRY REBUCK, SR.				2. DATE OF DEATH MONTH DAY YEAR JUNE 25, 1995		3. TIME OF DEATH 12:09 a.m.		
4. SOCIAL SECURITY NUMBER 216-16-9836		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 		7. DATE OF BIRTH (Month, Day, Year) Aug 17, 1920	8. BIRTHPLACE (State or Foreign Country) Pennsylvania	
9a. FACILITY NAME (If not institution, give street and number) SAINT JOSEPH MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON, MARYLAND		9c. COUNTY OF DEATH BALTIMORE		
RESIDENCE OF DECEDENT								
10e. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Cockeysville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 1 Brecon Place				10f. ZIP CODE 21030		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+		16b. KIND OF BUSINESS/INDUSTRY Teacher Education				
17. FATHER'S NAME (First, Middle, Last) Clarence Rebuck				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Roadarmel				
19e. INFORMANT'S NAME (Type/Print) Margaret J. Rebuck				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1 Brecon Place, Cockeysville, MD 21030				
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>Bryan W. Clary</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Grdns. June 28		20c. LOCATION — City or Town, State Timonium, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bryan W. Clary		22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home 10 W. Padonia Road, Timonium, MD 21093						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								
b. STATUS POST THORACOTOMY FOR A LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF):								
c. DUE TO (OR AS A CONSEQUENCE OF):								
d. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH X Natural 5 <input type="checkbox"/> Pending investigation 1 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Anthony H. Guarino, MD				29c. LICENSE NUMBER D 46673		29d. DATE SIGNED (Month, Day, Year) ► 6/25/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANTHONY H. GUARINO, MD 7620 YORK ROAD TOWSON, MD 21204								
31. DATE FILED JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19303

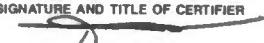
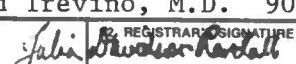
1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 12:45 am M	
VINCENT JOSEPH RINALDI									
4. SOCIAL SECURITY NUMBER 219-40-4361		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 52 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 9, 1943		8. BIRTHPLACE (State or Foreign Country) Mass.	
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center						9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Phoenix				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 14810 Manor Rd.						10f. ZIP CODE 21131		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 9-13-1968		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 yrs.		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (14 or 6+) N/A		16b. KIND OF BUSINESS/INDUSTRY Sunbelt Beverage Co.					
17. FATHER'S NAME (First, Middle, Last) Phillip Rinaldi						16. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Venezia			
19a. INFORMANT'S NAME (Type/Print) Mrs. C. Jeanne Rinaldi						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14810 Manor Rd. Phoenix, Md. 21131			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) Metro Crematory Inc.		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory Inc.		DATE 6-26-95		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard Hess		22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Baltimore, Md. 21236							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small Cell Carcinoma of lung with Metastases to spine DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. SPINE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. 									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertensive arteriosclerotic cardiovascular disease									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Alma (House Physician)						29c. LICENSE NUMBER D 42723	29d. DATE SIGNED (Month, Day, Year) 6/23/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AVVERAHALLIM M. HARASH, MD 3745 FOXFORD STREAM RD BALTO., MD 21236									
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Jane Shuler Harash							

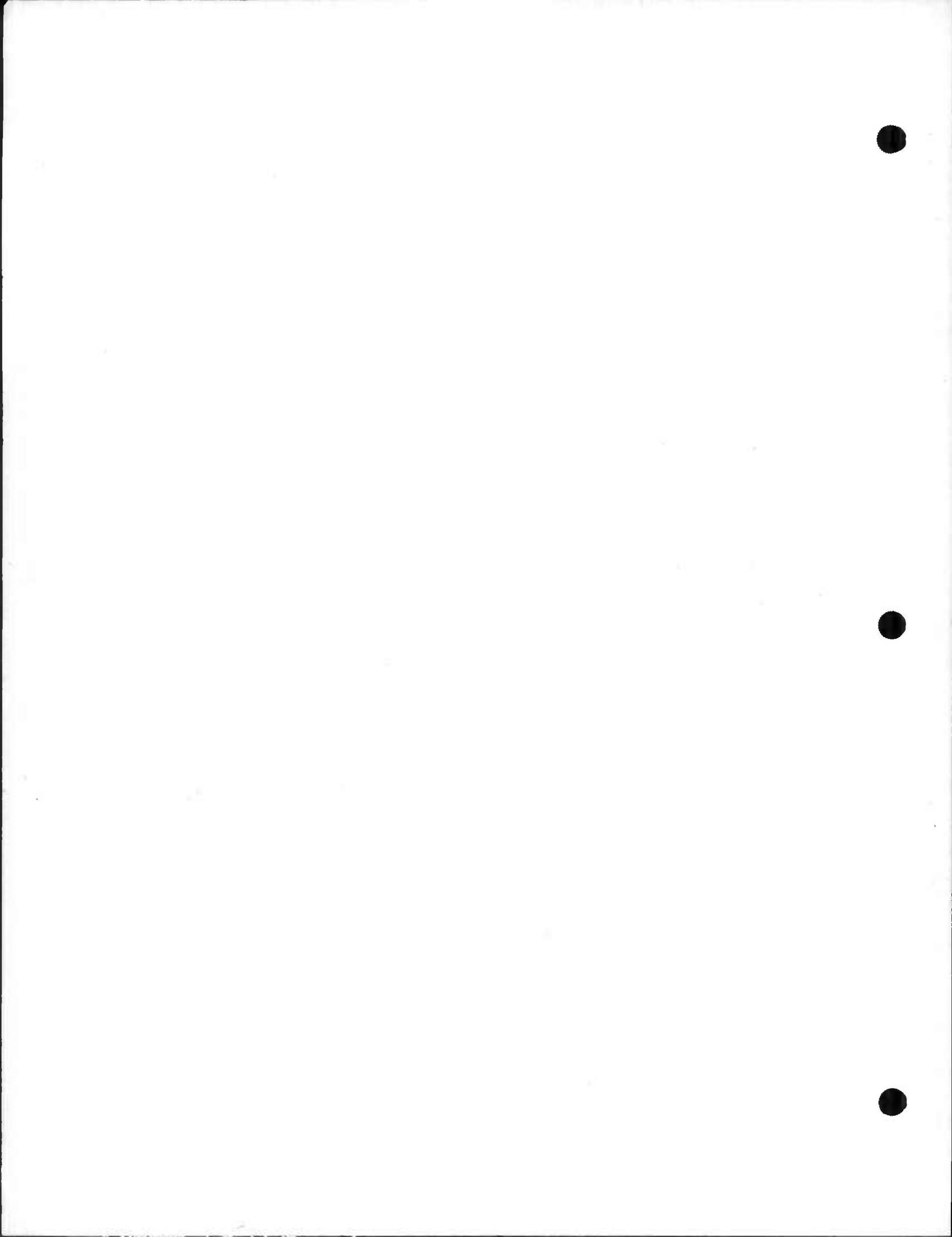
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) Myrtle C. SHAW										2. DATE OF DEATH MONTH DAY YEAR June 22 1995	3. TIME OF DEATH 11:30A M	
4. SOCIAL SECURITY NUMBER 235 36 2983		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 27, 1923			8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital Center										9b. CITY, TOWN OR LOCATION OF DEATH Rossville	9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEASED												
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Middle River								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 13 Tamarac Trail					10f. ZIP CODE 21220					10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Housewife			16b. KIND OF BUSINESS/INDUSTRY Own Home						
17. FATHER'S NAME (First, Middle, Last) Thomas Copley										16. MOTHER'S NAME (First, Middle, Maiden Surname) Lyda Hammon		
18a. INFORMANT'S NAME (Type/Print) Anthony L. Shaw					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Tamarac Trail Middle River, Maryland 21220							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem.			DATE 6/24/95	20c. LOCATION — City or Town, State Baltimore Co., Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Bruzdzinski Funeral Home P.A.							
					1407 Eastern Ave Baltimore, Maryland 21221							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 3 weeks		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST 												
s. Hypoperfusion DUE TO (OR AS A CONSEQUENCE OF):												
b. Multisystem failure DUE TO (OR AS A CONSEQUENCE OF):												
c. Acute nonlymphocytic leukemia DUE TO (OR AS A CONSEQUENCE OF):												
d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive pulmonary disease										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Undetermined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER RD1668	29d. DATE SIGNED (Month, Day, Year) June 22, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David Trevino, M.D. 9000 Franklin square Drive Baltimore, MD 21237												
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

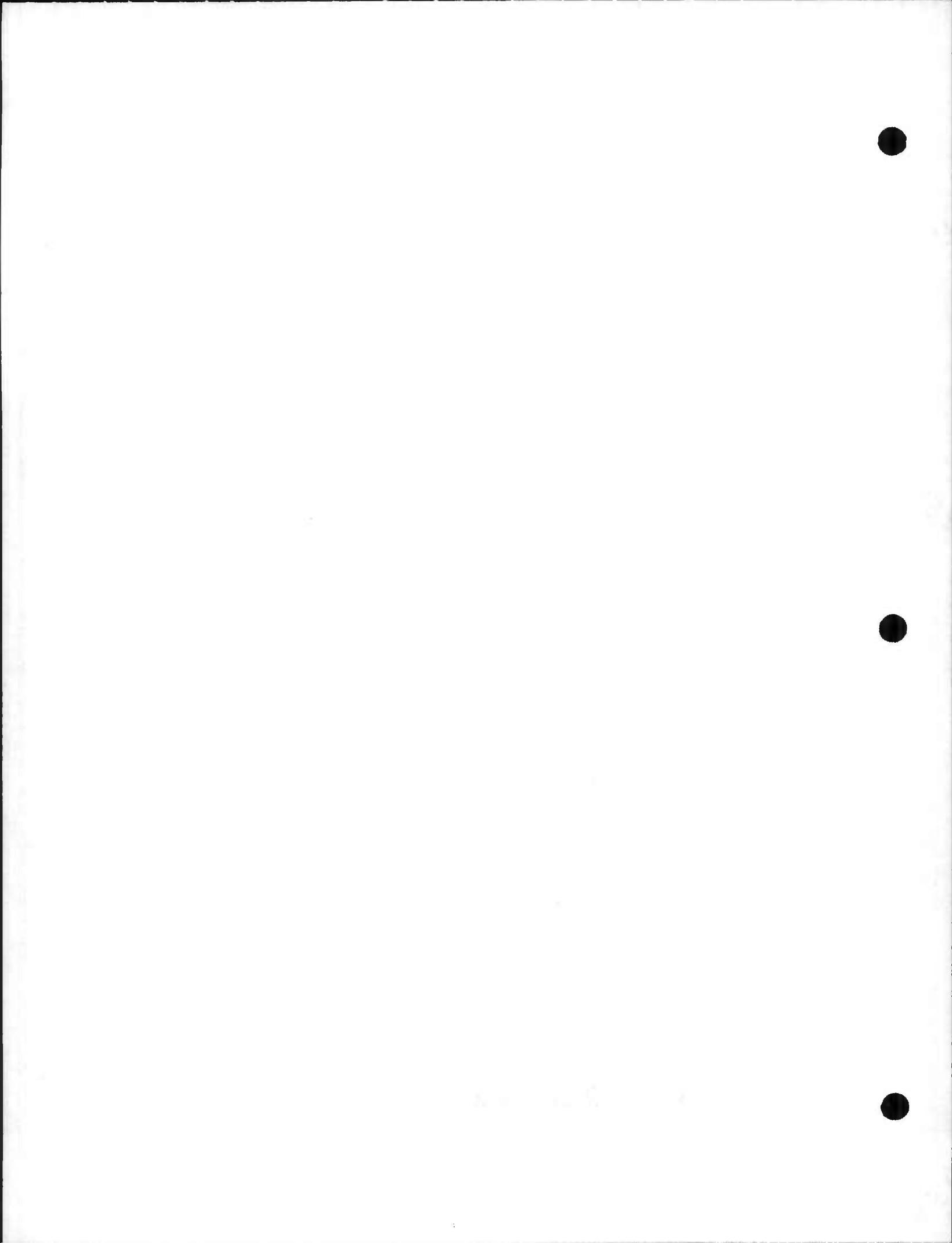
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19305

1. DECEASED'S NAME (First, Middle, Last) Mary C. Shannon							2. DATE OF DEATH MONTH DAY YEAR June 21 1995	3. TIME OF DEATH 11:38 P.M.
4. SOCIAL SECURITY NUMBER 218-22-0255		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. less birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.			
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Catonsville					7. DATE OF BIRTH (Month, Day, Year) Sept 2, 1915	8. BIRTHPLACE (State or Foreign Country) Maryland
9c. COUNTY OF DEATH Baltimore								
RESIDENCE OF DECEASED								
10e. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Baltimore					10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 301 Camrose Ave				10f. ZIP CODE 21225			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Housewife			
17. FATHER'S NAME (First, Middle, Last) Harry Burns				16. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Schwartzkoff				
19e. INFORMANT'S NAME (Type/Print) Mrs Patricia Heil				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 755 Gaither Road, Sykesville, Md 21784				
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Memorial Park			DATE 6/24	20c. LOCATION — City or Town, State Glen Burnie, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E. Davis				22. NAME AND ADDRESS OF FACILITY Gonce Funeral Home 4001 Ritchie Highway Balto, Md 21225				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								
a. SEPSIS DUE TO (OR AS A CONSEQUENCE OF): Gangrene of the feet								
b. DUE TO (OR AS A CONSEQUENCE OF): Gangrene of the feet								
c. DUE TO (OR AS A CONSEQUENCE OF): Gangrene of the feet								
d. DUE TO (OR AS A CONSEQUENCE OF): Gangrene of the feet								
Approximate Interval Between Onset and Death one week								
Few weeks								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
Multi-Infarct Dementia								
Hypertension								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year) 6/23/95		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED fall		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4001 Ritchie Highway Balto, Md 21225						
29e. CERTIFIER (Check only one) XX CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER N. B. VELLANKI, MD.		29c. LICENSE NUMBER D30469.			29d. DATE SIGNED (Month, Day, Year) ► June 23 1995.			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. B. VELLANKI, MD., 9055, Chevrolet Drive #100, Ellicott City, MD 21042								
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Julie Deinrichs						



95 19306

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

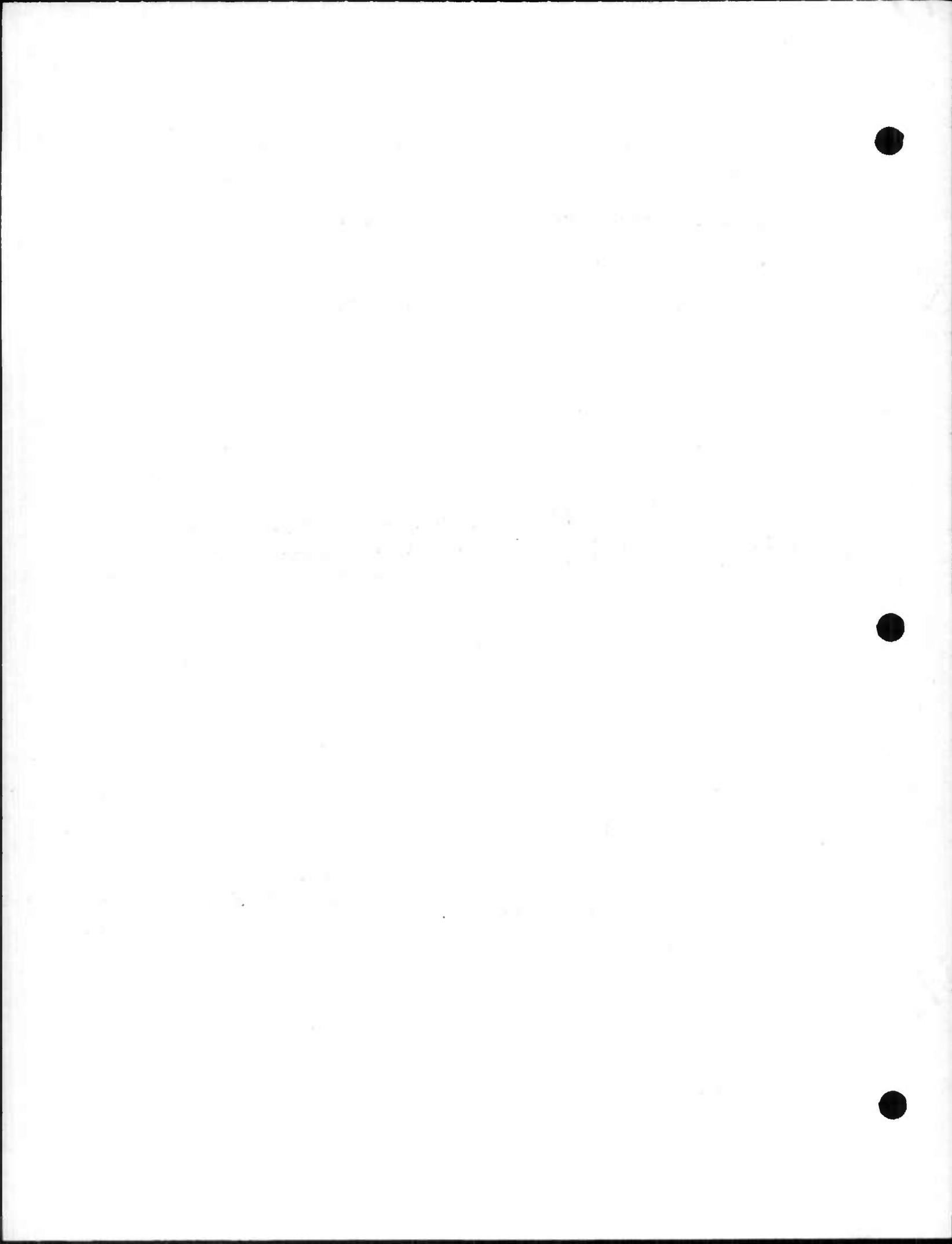
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 18:23 PM		
KERI ANN SIRBAUGH												JUNE 21, 1995			
4. SOCIAL SECURITY NUMBER 214-15-2135		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 21 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8/9/1973		8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) 6400 BLK. EVERALL AVE.												9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT															
10a. STATE Maryland	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore										10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 6420 Everall Avenue						10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 3				16b. KIND OF BUSINESS/INDUSTRY Full Time Student				16c. DATE 20c. LOCATION — City or Town, State Parkwood Cemetery 6/26/95 Baltimore, Maryland					
17. FATHER'S NAME (First, Middle, Last) William Sirbaugh						18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Weaver									
19a. INFORMANT'S NAME (Type/Print) Mr. William Sirbaugh						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3507 Chesley Avenue Baltimore, Md. 21234									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery				20c. DATE 20c. LOCATION — City or Town, State 6/26/95 Baltimore, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoyna ► <i>Mark T. Zavoyna</i>						22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Strangulation and Blunt Force Injuries DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. _____ c. _____ d. _____ }															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) IN WOODS													
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) Found 6-21-95		28b. TIME OF INJURY Found 1820p.m.	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED subject strangled and beaten		28e. PLACE OF INJURY — At home, farm, street, factory, office woods		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 6420 Everall Ave Baltimore, Md.					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chitewa</i>						29c. LICENSE NUMBER OCME				29d. DATE SIGNED (Month, Day, Year) ► JUNE 22, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201															
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Irlia Shuler-Purcell</i>													



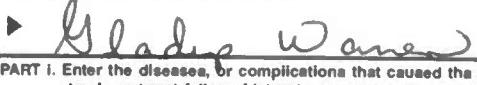
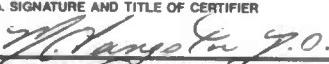
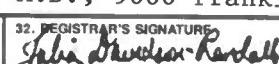
DIVISION OF VITAL RECORDS, P.O. BOX 68760

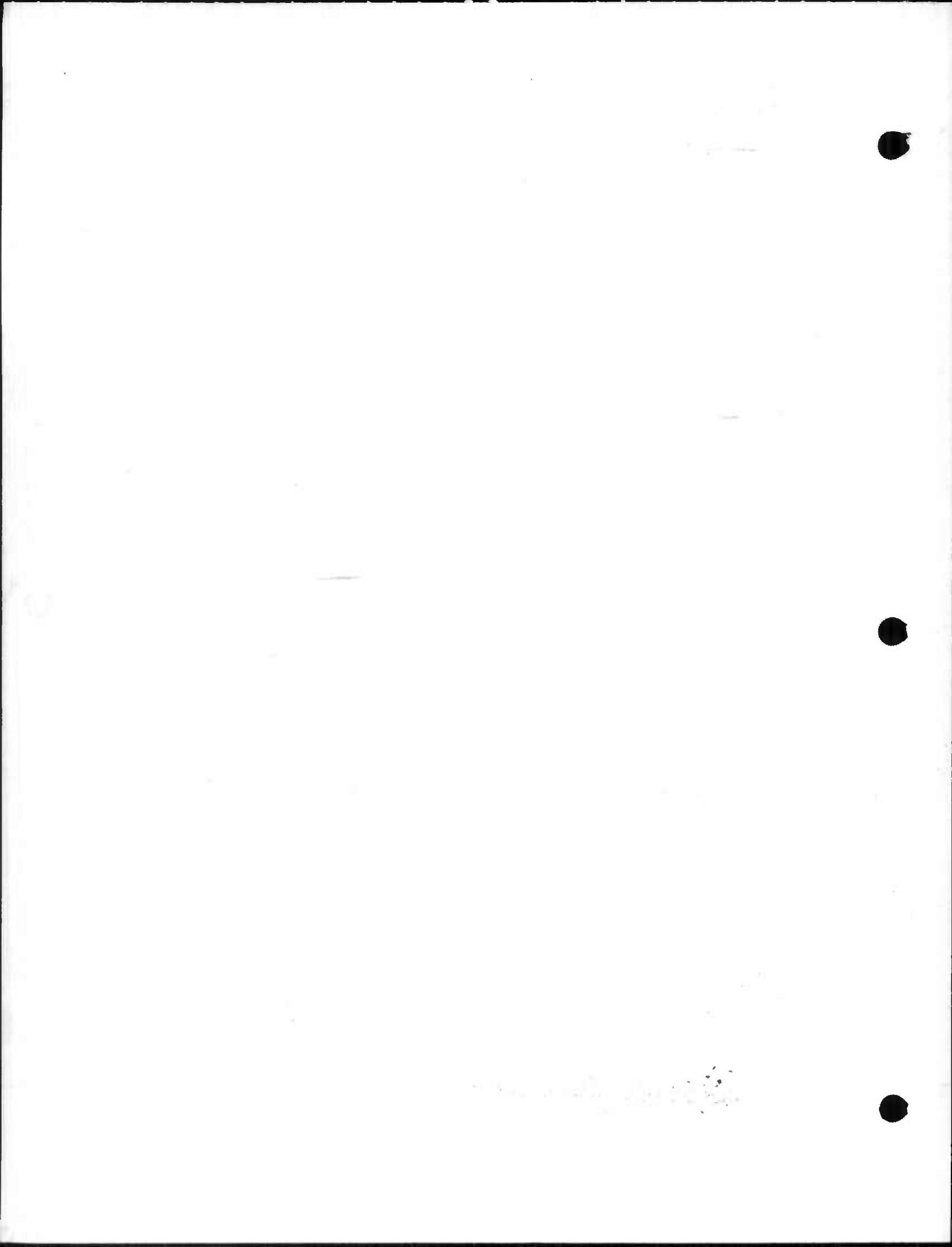
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Aslam Mohammad Aslam SIDIQUI										2. DATE OF DEATH MONTH DAY YEAR June 25, 1995	3. TIME OF DEATH 3:45 p.m.
4. SOCIAL SECURITY NUMBER 151-90-5100		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept 22, 1922		8. BIRTHPLACE (State or Foreign Country) Pakistan	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Rosedale	9c. COUNTY OF DEATH Baltimore County
10a. STATE Md		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 30 Glenway				10f. ZIP CODE 21236				10g. CITIZEN OF WHAT COUNTRY? Pakistan			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Pakistan	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (14 or 5+) 4 years Civil Engineer				16b. KIND OF BUSINESS/INDUSTRY Engineer					
17. FATHER'S NAME (First, Middle, Last) Fazal Qadir Siddiqui										18. MOTHER'S NAME (First, Middle, Maiden Surname) Hukum Jan	
19a. INFORMANT'S NAME (Type/Print) Junaid Siddiqui					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 30 Glenway Baltimore, Md 21239						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King Memorial Park				DATE 6205 Randallstown, Md		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Habah Wabash Avenue Baltimore, Md 21215						
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac Dysrhythmia										Approximate Interval Between Onset and Death 1 year	
e. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
b. Ischemic Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF): d. Atherosclerosis										1 year 4 years 4 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure Bacteremia Diabetes Mellitus II, Hypertension										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER RD 1777				29d. DATE SIGNED (Month, Day, Year) ► 6/25/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Monique Langston, M.D., 9000 Franklin Square Drive, Baltimore, Maryland 21237											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

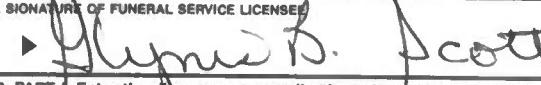
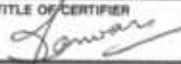
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

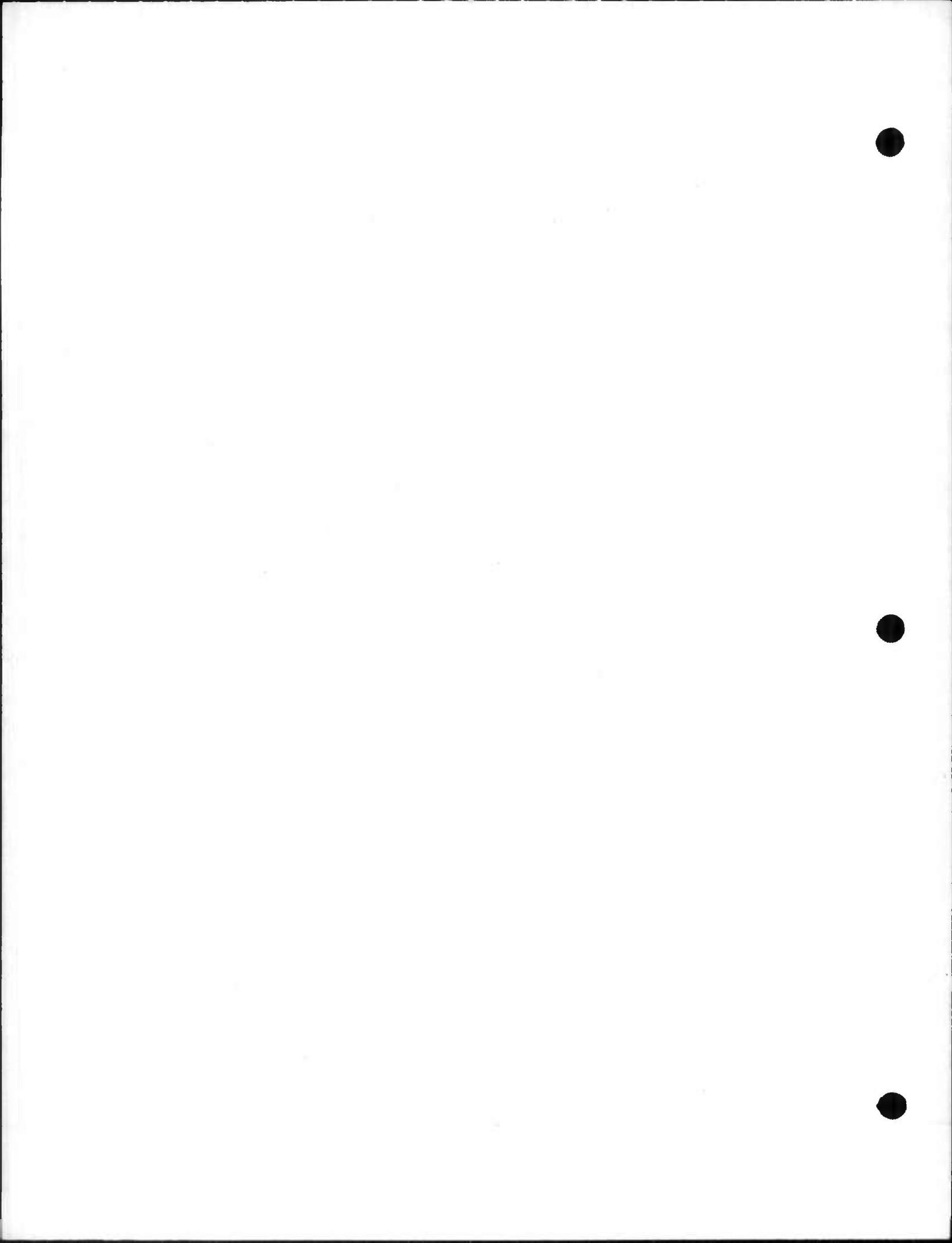
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 22 1995										3. TIME OF DEATH 4:25 P M	
1. DECEDENT'S NAME (First, Middle, Last) Leroy Singletary													
4. SOCIAL SECURITY NUMBER 251-42-9643		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. least birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month Day Year) DEC 1 1931		8. BIRTHPLACE (State or Foreign Country) S C					
8a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	9c. COUNTY OF DEATH N/A
RESIDENCE OF DECEDENT													
10a. STATE MD	10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTO			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 1100 APPLETON ST.				10f. ZIP CODE 21217			10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 11-3-53 3-11-54			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: BLACK			14. RACE — American Indian, Black, White, etc. Specify: BLACK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) N/A			16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION WORKER			16c. KIND OF BUSINESS/INDUSTRY CONSTRUCTION					
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIE MAE SINGLETON									
19a. INFORMANT'S NAME (Type/Print) MINNIE LOWERY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3211 BELMONT AVE BALTO, MD 21217									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VET			DATE	20c. LOCATION — City or Town, State 62795 OWINGS MILLS MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY MARCH F/H-WEST 4300 WABASH AVE									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Aspiration pneumonia												3 days	
b. Sepsis DUE TO (OR AS A CONSEQUENCE OF):												3 days	
c. Myocardial infarction DUE TO (OR AS A CONSEQUENCE OF):												3 days	
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)									28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 											29c. LICENSE NUMBER 89234		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Shakir Sarwar, MD c/o Maryland General Hospital 827 Linden Ave											29d. DATE SIGNED (Month, Day, Year) 6/22/95		
31. DATE FILED (Month, Day, Year) JUN 26 1995													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

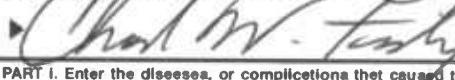
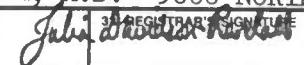
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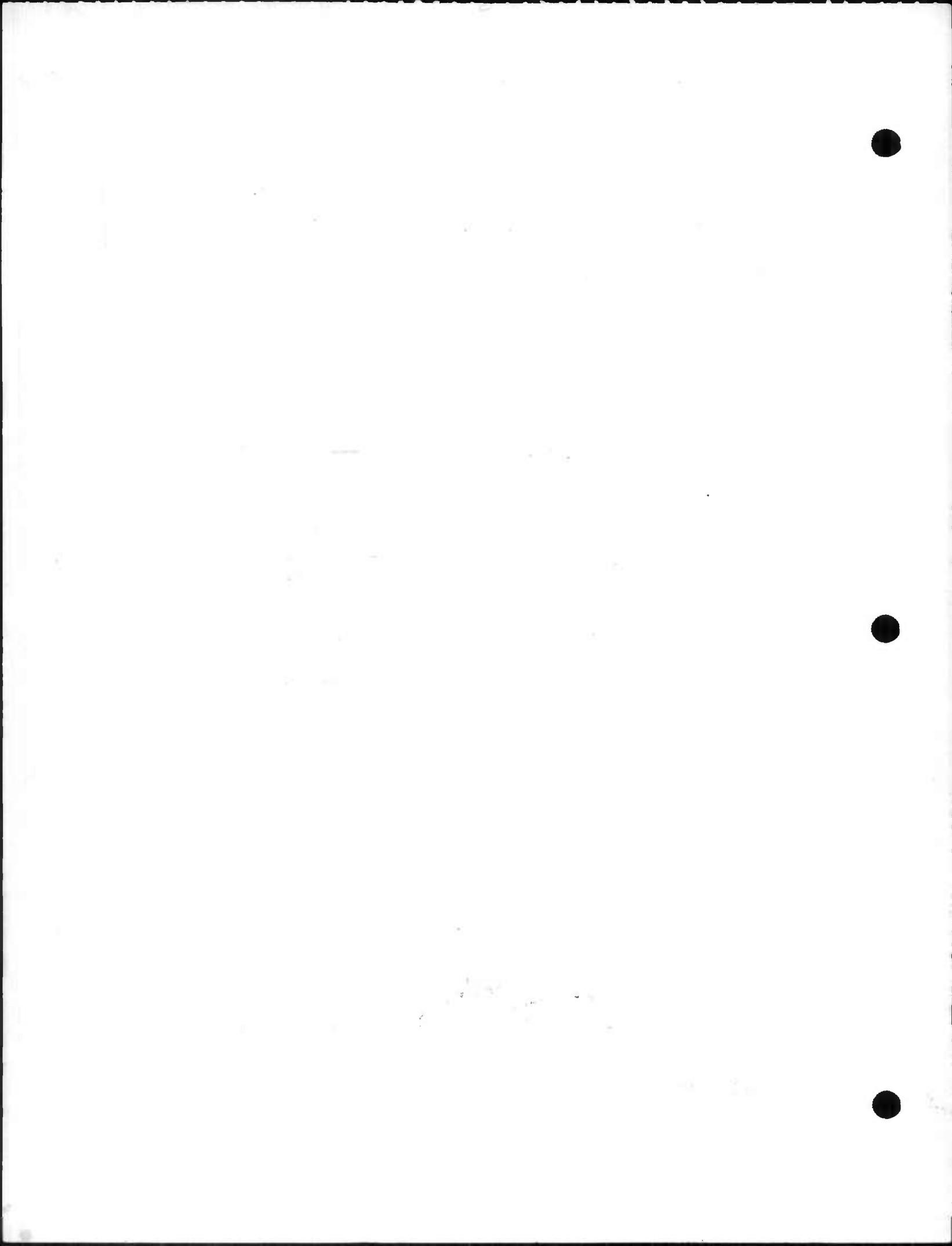
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FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ALFRED BURDICK SLATER				2. DATE OF DEATH MONTH JUNE DAY 21, 1995 YEAR	3. TIME OF DEATH 9:50 A M	
4. SOCIAL SECURITY NUMBER 216-12-3923		5. SEX 1 X M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 1, 1923	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview Medical Ctr.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH N/A
10e. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Dundalk		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 X NO
10e. STREET AND NUMBER 3127 Dunglow Road				10f. ZIP CODE 21222	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 X Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 X NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Self Employed		16b. KIND OF BUSINESS/INDUSTRY Painter		
17. FATHER'S NAME (First, Middle, Last) Herbert William Slater, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna Marie Hilker		
19e. INFORMANT'S NAME (Type/Print) Miriam J. Hagan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3127 Dunglow Road Dundalk, Maryland 21222		
20e. METHOD OF DISPOSITION 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery		DATE 6/24/95	20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, MD 21222		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) →						
<p>a. MASSIVE MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. SECONDARY TO HYPERTENSIVE ARTERIAL VASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>						
Approximate Interval Between Onset and Death minutes						
years						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 X NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 X ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		OTHER: 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
27. MANNER OF DEATH 1 X Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
29e. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER DO 9264		29d. DATE SIGNED (Month, Day, Year) ► 6-21-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AMABLE MENDOZA, M.D.—9600 NORTH POINT ROAD, FORT HOWARD, MARYLAND 21052						
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

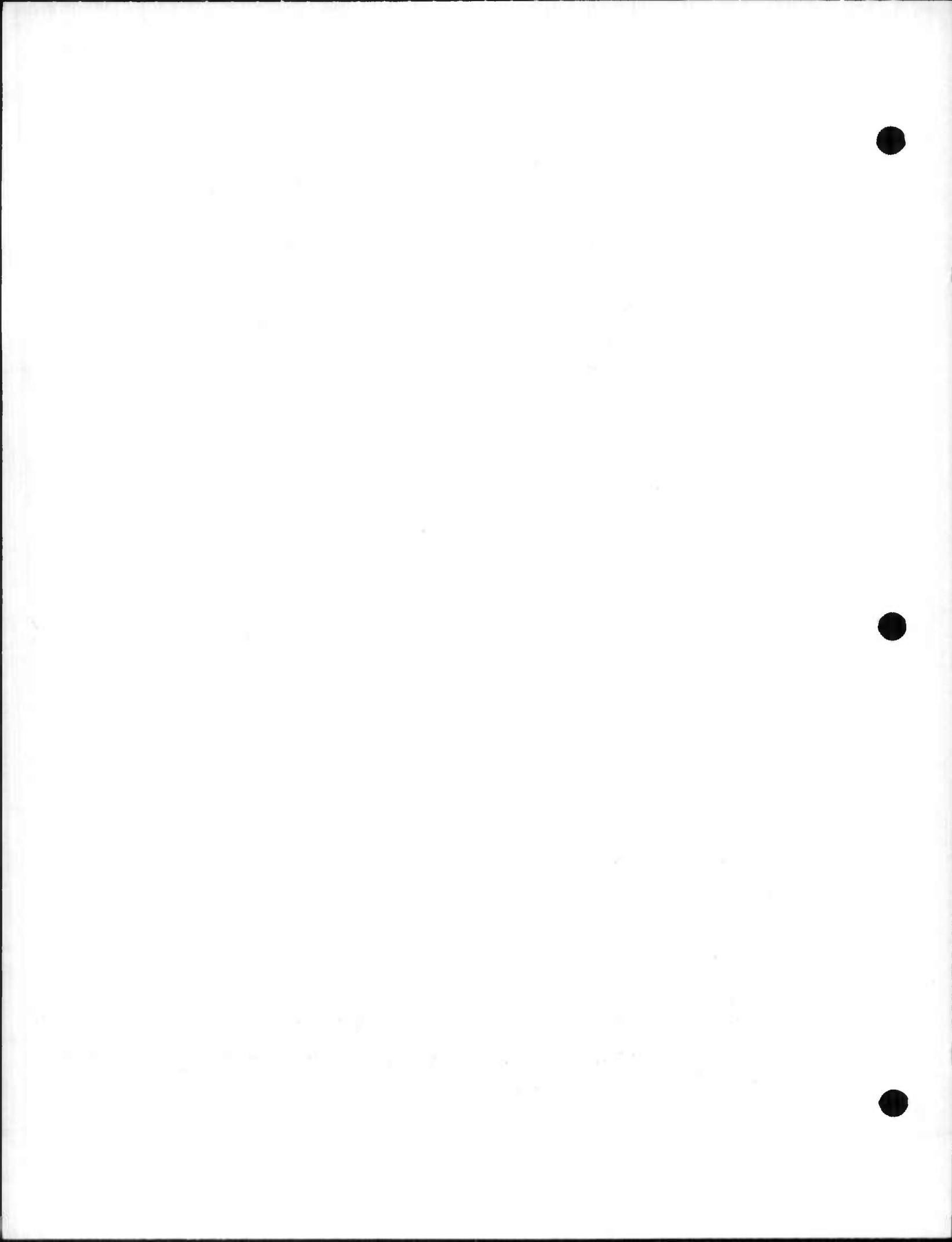
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Julia Schnitman										June 22, 1995	8:20a M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
577 36 4196		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	94 YRS.	MONTHS	DAYS	HOURS	MIN.			July 17, 1900	South Carolina
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Holy Cross Hospital										Silver Spring	Montgomery
RESIDENCE OF DECEDENT											
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
Maryland	Montgomery	Chevy Chase									
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY? 1 <input type="checkbox"/> USA
2632 Colston Drive										20815-3036	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Philip Shade										Tillie Siegal	
19a. INFORMANT'S NAME (Type/Print)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Frederick S. Schnitman					same as #10 above						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Mem. Gdns 6/25/95				DATE		20c. LOCATION — City or Town, State Olney, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Edward Parker</i>					22. NAME AND ADDRESS OF FACILITY Ives-Pearson Funeral Homes Falls Church, VA 22046						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 1 week	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>upper gastrointestinal bleeding</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
8 <input type="checkbox"/> Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter E. Goode MD</i>										29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
										DO 1120	<i>JUNE 28, 1995</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>WALTER E. GOODE MD 2309 SHAREFIELD Road WHEATON, MD 20902</i>											
31. DATE <i>JUN 28 1995</i>										RECEIVED BY REGISTRAR'S SIGNATURE <i>John Edward Parker</i>	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

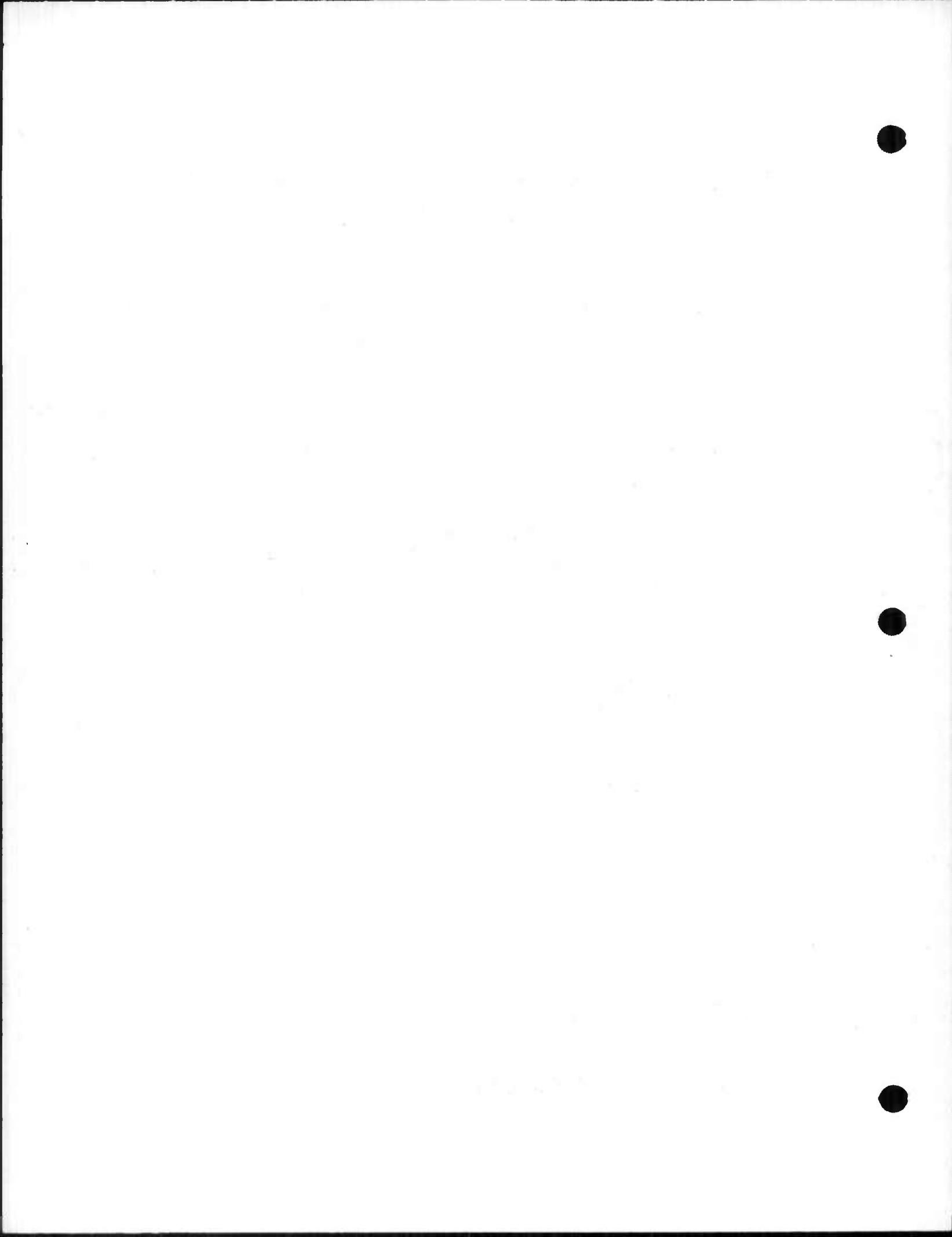
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
Irene E. Swain											June 15, 95	95 08 40 AM	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
234-34-9510		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		86 YRS.		MONTHS DAYS		HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH										9c. COUNTY OF DEATH	
NORTHWEST MEDICAL CENTER		RANDALLSTOWN										BALTIMORE	
RESIDENCE OF DECEDENT													
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
MD.	BALTIMORE		REISTERSTOWN										
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?			
12020 REISTERSTOWN RD.		21136								U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
1 N/A		College (1-4 or 5+)											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)												16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	16b. KIND OF BUSINESS/INDUSTRY
Elementary/Secondary (0-12)						BEAUTICIAN				SWAIN'S BEAUTY SHOP			
17. FATHER'S NAME (First, Middle, Last)												18. MOTHER'S NAME (First, Middle, Maiden Surname)	
EDWARD CUSACK												CORA MAY SWITZER	
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										92107	
ONALINE FRYE		2101 CHATSWORTH BLVD. #13 SAN DIEGO, CA.											
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place)				DATE		20c. LOCATION — City or Town, State					
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		GREENLAWN MEM. PARK				6-16-95		AKRON, OHIO					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY										2829 HUDSON ST. SKARDA FH. BALTO., MD. 21224	
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. ISCHEMIC CARDIOMYOPATHY DUE TO (OR AS A CONSEQUENCE OF):													
b. _____ DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
CHRONIC OBSTRUCTIVE PULMONARY DISEASE DIMENTIA													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)											
		HOSPITAL:		OTHER: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH		1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)		1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER								29d. DATE SIGNED (Month, Day, Year)			
Alice Hsieh		H43974								June 15, 95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
Alice Hsieh, Northwest Hospital, Randallstown, MD													
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE										DHMH-16 Rev 1/99	
JUN 26 1995		John Blasius											



95 19312

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

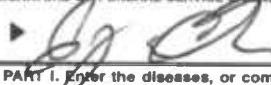
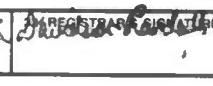
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

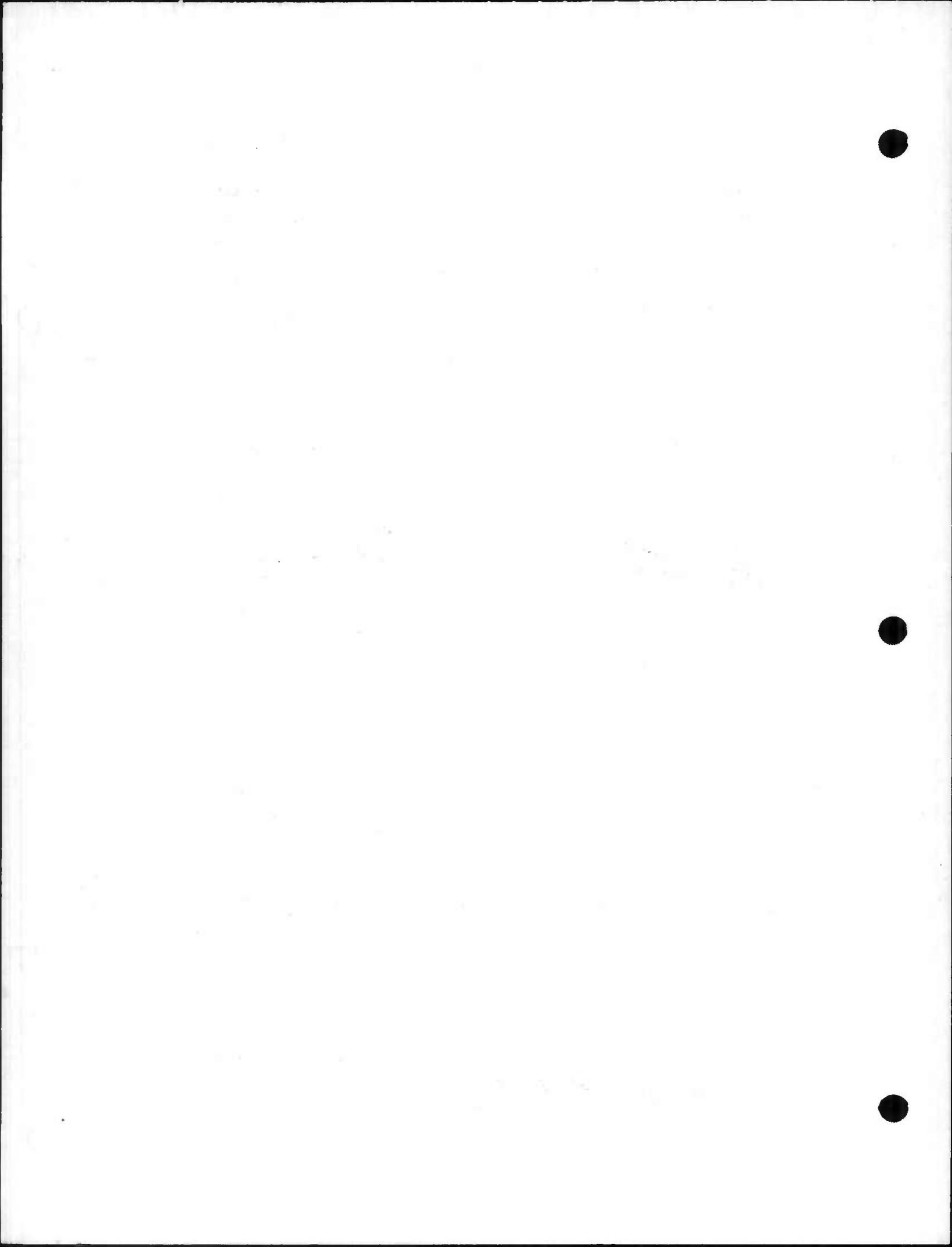
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

BALTIMORE, MARYLAND 21215-0020

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) JOSHUA H. SAYLOR							2. DATE OF DEATH MONTH JUNE DAY 21 YEAR 95		3. TIME OF DEATH 5:00 P.M.		
4. SOCIAL SECURITY NUMBER 143643437		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 20 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY S.T.U.							7. DATE OF BIRTH (Month, Day, Year) JULY 8, 1974		8. BIRTHPLACE (State or Foreign Country) NEW JERSEY		
9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY							9c. COUNTY OF DEATH N/A				
10a. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION ROSEDALE					10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 908 ROSEDALE AVENUE							10f. ZIP CODE 21237		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED			16b. KIND OF BUSINESS/INDUSTRY N/A						
17. FATHER'S NAME (First, Middle, Last) THEODORE E. SAYLOR JR.							18. MOTHER'S NAME (First, Middle, Maiden Surname) PATRICE SOSSICK				
19a. INFORMANT'S NAME (Type/Print) PATRICE SAYLOR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 908 ROSEDALE AVE ROSEDALE, MARYLAND 21237							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARDENS OF FAITH			DATE 6/26	20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTIMORE, MD 21237							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple injuries</i> a. _____ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): <i>multiple injuries</i>											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. _____ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): <i>multiple injuries</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY 6-21-95	28b. TIME OF INJURY 1545p M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED waterski struck bridge			28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) Baltimore Gunpowder River	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 							29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201											
31. DATE FILED (Month, Day, Year) JUN 26 1995				32. REGISTRATION SIGNATURE 						DHMH-16 Rev 1/99	



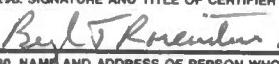
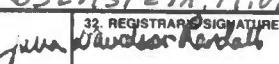
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

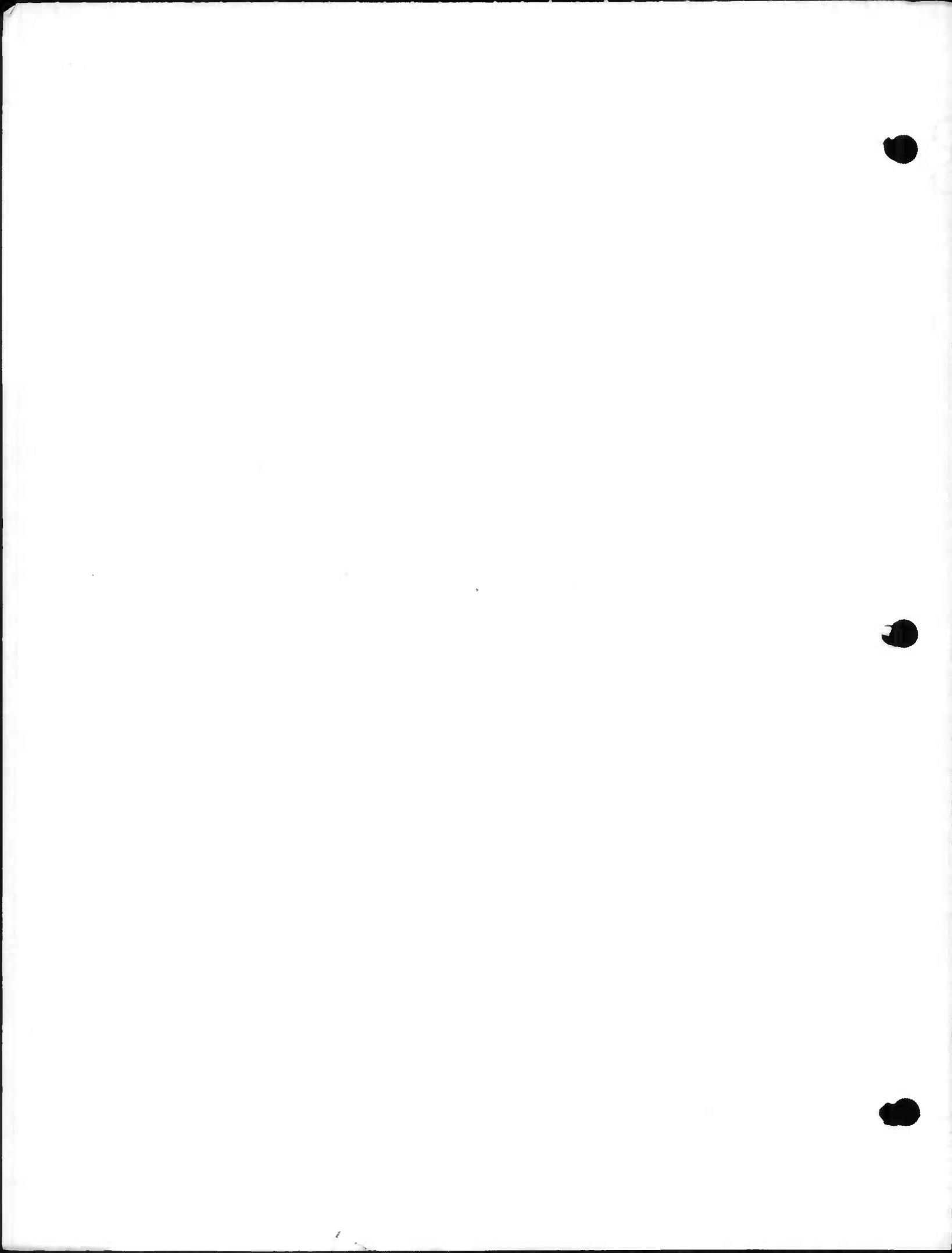
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) JOSEPH ANTON SMUTEK										2. DATE OF DEATH MONTH DAY YEAR JUNE 24, 1995	3. TIME OF DEATH 2:40am M
4. SOCIAL SECURITY NUMBER 214-50-3022		5. SEX M	6. AGE (In yrs. last birthday) 49 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) MARCH 2, 1946			8. BIRTHPLACE (State or Foreign Country) MD
9a. FACILITY NAME (If not institution, give street and number) 1737 JACKSON STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEDENT											
10a. STATE MD	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? YES 2 NO					
10e. STREET AND NUMBER 1737 JACKSON STREET				10f. ZIP CODE 21230				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECENDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) N/A			16b. KIND OF BUSINESS/INDUSTRY DISABLED			N/A			
17. FATHER'S NAME (First, Middle, Last) WALTER SMUTEK				18. MOTHER'S NAME (First, Middle, Maiden Surname) THERESA E. KOERBER							
19a. INFORMANT'S NAME (Type/Print) GLADYS R. ELLENBERGER				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1737 JACKSON STREET, BALTIMORE, MD 21230							
20a. METHOD OF DISPOSITION X <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY, JUNE 27, 1995				DATE	20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 											
22. NAME AND ADDRESS OF FACILITY CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVENUE, BALTIMORE, MD 21230											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
e. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF):											
Approximate Interval Between Onset and Death 6 MONTHS											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {											
b. CYSTIC FIBROSIS DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER X <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER  BERT J. ROSENSTEIN, M.D.		29c. LICENSE NUMBER D09701				29d. DATE SIGNED (Month, Day, Year) 6/26/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BERT J. ROSENSTEIN, M.D., JOHNS HOPKINS HOSPITAL, BALTIMORE 21287											
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. 95 19314		
		1. DECEDENT'S NAME (First, Middle, Last) FRANCES CECILIA SHIPLEY				2. DATE OF DEATH MONTH DAY YEAR JUNE 23 1995		3. TIME OF DEATH 2PM			
		4. SOCIAL SECURITY NUMBER 215-50-3227		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 91 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) NOV. 4, 1903		
		8a. FACILITY NAME (If not institution, give street and number) AUGSBURG LUTHERAN HOME		8b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE MD		8c. COUNTY OF DEATH BALTIMORE		8. BIRTHPLACE (State or Foreign Country) Maryland			
		9a. RESIDENCE OF DECEDENT 10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		10e. STREET AND NUMBER 6811 Campfield Road				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Home Maker		16b. KIND OF BUSINESS/INDUSTRY own home					
		17. FATHER'S NAME (First, Middle, Last) Edward Karl Huppert		18a. MOTHER'S NAME (First, Middle, Maiden Surname) Cecelia Unknown Haselack							
		19a. INFORMANT'S NAME (Type/Print) Charles W. Smith		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1808 Belle Avenue Baltimore, Md. -21222							
		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Moreland Memorial Park		DATE 6-26	20c. LOCATION — City or Town, State Baltimore, Maryland				
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE Kathleen M. Murphy		22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. Baltimore, Maryland		6415 Belair Road					
		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Myocardial infarct</i> DUE TO (OR AS A CONSEQUENCE OF): <i>ischemic heart disease</i>		Approximate Interval Between Onset and Death 5 days					
		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF): <i>hypertension</i>		c. DUE TO (OR AS A CONSEQUENCE OF): <i>hypertension</i>		d. DUE TO (OR AS A CONSEQUENCE OF): <i>hypertension</i>			
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26a. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26b. DATE OF INJURY (Month, Day, Year) NA		26c. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED	
		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. DESCRIBE HOW INJURY OCCURRED		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
		29b. SIGNATURE AND TITLE OF CERTIFIER Harold B. Boe		29c. LICENSE NUMBER D15872		29d. DATE SIGNED (Month, Day, Year) June 23 1995					
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Harold B. Boe 7220 Park Heights 21208									
		31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Lin Shuler-Pattell							

220-230

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

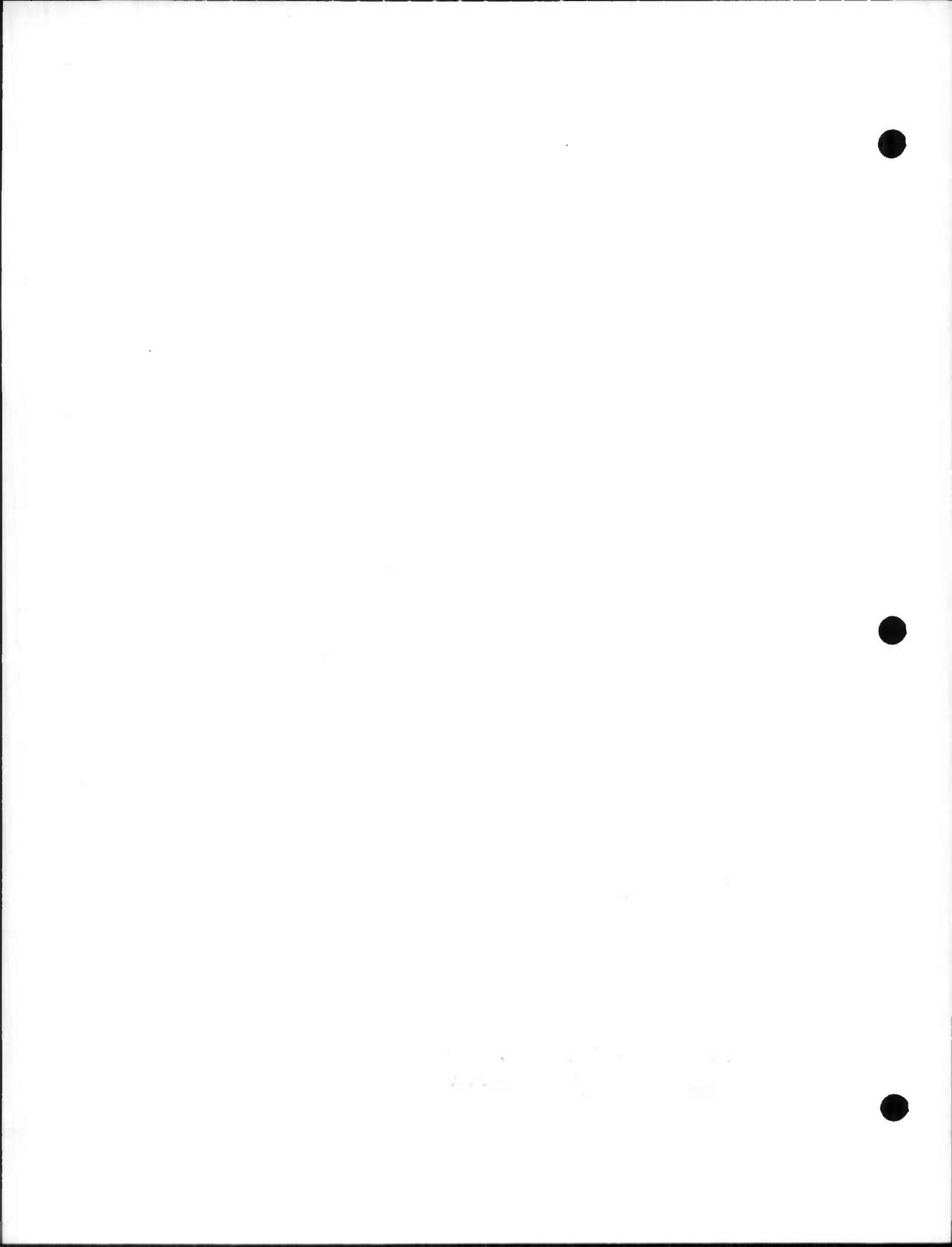
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) MARGARET P. TRIBULL								2. DATE OF DEATH MONTH DAY YEAR June 22, 1995		3. TIME OF DEATH 7:38 P.M.	
4. SOCIAL SECURITY NUMBER 215-03-9965		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct 25, 1907		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 605 Brian Street								9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEASED											
10a. STATE Maryland	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Pasadena				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 8876 Fort Smallwood Road					10f. ZIP CODE 21122		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Book Binder			18b. KIND OF BUSINESS/INDUSTRY Book Binding					
17. FATHER'S NAME (First, Middle, Last) Herman Gunther					18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Schaffer						
19a. INFORMANT'S NAME (Type/Print) Margaret E. Harris				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 605 Brian Street, Baltimore, Maryland 21225							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park			DATE 6/26	20c. LOCATION — City or Town, State Baltimore Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E Davis				22. NAME AND ADDRESS OF FACILITY Gonce Funeral Home 4001 Ritchie Highway, Balto, Md 21225							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Breast Cancer											
Approximate Interval Between Onset and Death 2 years											
b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Elliott Gorbaty M.D.				29c. LICENSE NUMBER D20094 MD		29d. DATE SIGNED (Month, Day, Year) ► 6/23/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliott Gorbaty M.D. 7845 Oakwood Road Suite 203 Glen Burnie, Md 21061											
31. DATE FILED (Month, Day, Year) JUN 2 6 1995		32. MEDICAL SIGNATURE [Signature]									

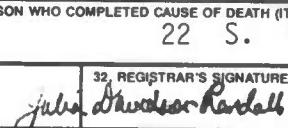


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 8:16 P M		
DONALD ALVIN THOMPSON, SR.												June 17, 1995			
4. SOCIAL SECURITY NUMBER 212-46-9221		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 46 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) APR. 14, 1949		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 4021 Kathland Avenue												9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE MD		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 4021 Kathland Avenue						10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black						
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) G.E.D.			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) — Janitor			16b. KIND OF BUSINESS/INDUSTRY London Fog Clothing									
17. FATHER'S NAME (First, Middle, Last) Charles Thompson						18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Watkins									
19a. INFORMANT'S NAME (Type/Print) Vanessa Thompson						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4021 Kathland Ave./Baltimore, MD 21207									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) ARLBUTUS MEMORIAL PARK			DATE 6-22		20c. LOCATION — City or Town, State ARLBUTUS, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY March Funeral Home East 21202 1101 E. North Ave./Baltimore, Maryland									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 7 MO			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. NON-SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF):															
b. _____ DUE TO (OR AS A CONSEQUENCE OF):															
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER ROGERIO C. LILENBAUM M.D.		29c. LICENSE NUMBER D47116		29d. DATE SIGNED (Month, Day, Year) ► 6/21/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 22 S. GREENE STREET, BALTIMORE, MARYLAND 21201															
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 													

4/15/10

4/17/10

WCEP, BALTIMORE, MARYLAND

FilmG, 724, item #1, 6/26/95, cyw, per f.h.

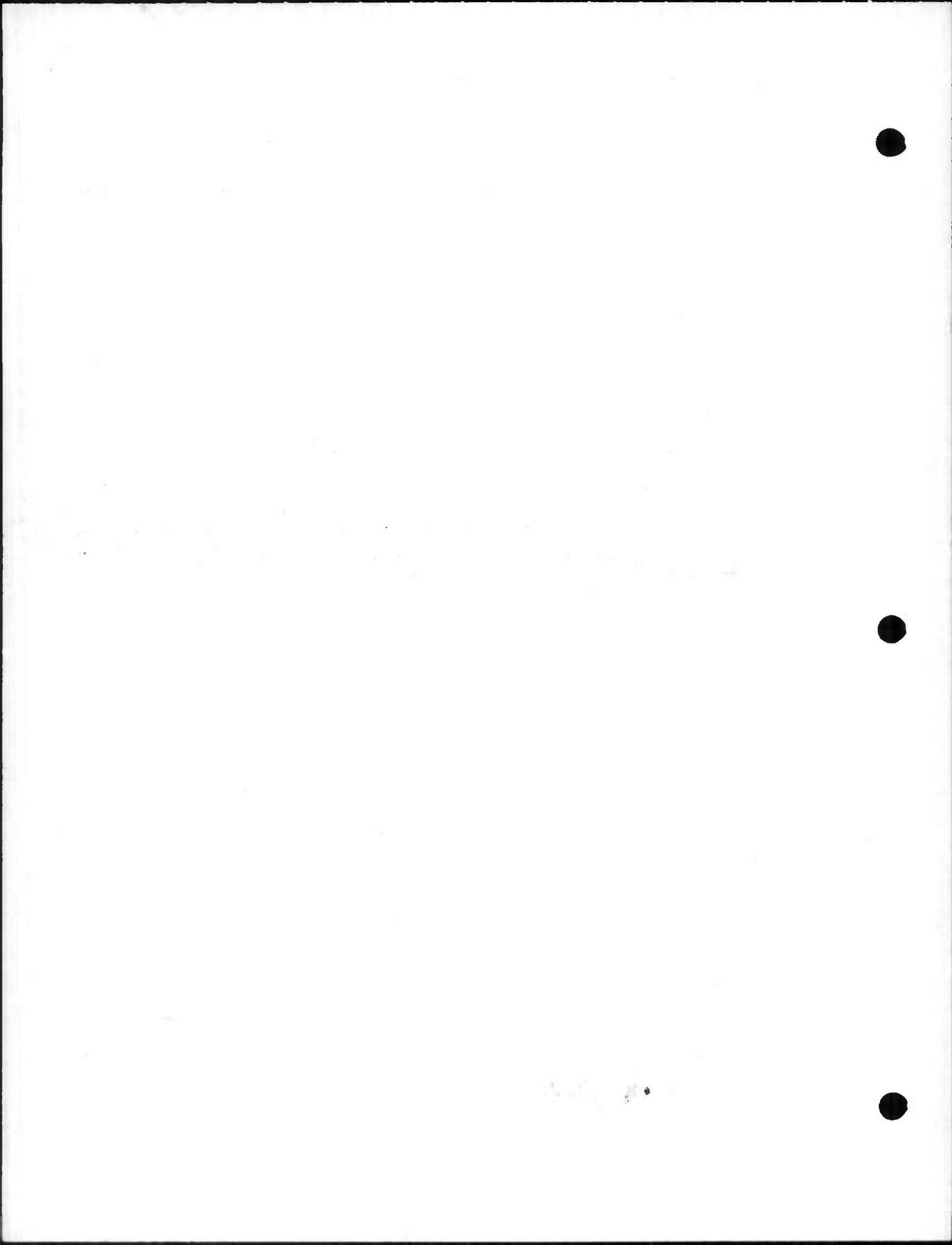
95 19317

FOR
1 - STATE
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		TARTER, Jr				2. DATE OF DEATH MONTH JUNE DAY 21, 1995 YEAR	3. TIME OF DEATH 10:16 P.M.
JEFFERY JEFFREY Lynn						7. DATE OF BIRTH (Month, Day, Year) April 20, 1981	
4. SOCIAL SECURITY NUMBER 217-15-1284		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 14 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH n/a	
RESIDENCE OF DECEDENT							
10e. STATE Maryland	10b. COUNTY n/a	10c. CITY, TOWN OR LOCATION Pikesville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8114 Streamwood Drive				10f. ZIP CODE 21208		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th Grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) student		16b. KIND OF BUSINESS/INDUSTRY Old Court Middle School			
17. FATHER'S NAME (First, Middle, Last) Jeffrey L. Tarter, Sr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Veronica Russell			
19a. INFORMANT'S NAME (Type/Print) Jeffrey L. Tarter, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8114 Streamwood Drive Pikesville, Maryland 21208					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from Scene <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD Veteran Cemetery/Garrison		20c. LOCATION — City or Town, State Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest R. Emery Jr.</i>		22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes, Inc 2501 Gwynns Falls Parkway Baltimore, Maryland 21216					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DISSECTING AORTIC ANEURYSM DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dennis J. Chute M.D.</i>		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dennis Chute M.D.		111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Jahnie Anderson-Randall</i>					

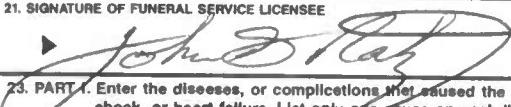
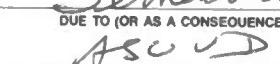


DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR												
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
Kathryn Marie Wolfe										JUNE 20, 1995	8:30 A.M.	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
401-14-7131		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	96 YRS.	MONTHS	DAYS	HOURS	MIN.	AUG. 1, 1898		Kentucky		
9a. FACILITY NAME (If not institution, give street and number) 1600 Dennis Avenue										9b. CITY, TOWN OR LOCATION OF DEATH Towson		
9c. COUNTY OF DEATH Baltimore County												
RESIDENCE OF DECEDENT												
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
Maryland	Baltimore County		Towson									
10e. STREET AND NUMBER 1600 Dennis Avenue										10f. ZIP CODE 21204	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
Elementary/Secondary (0-12) 8		College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) James Harrison Wolfe										16c. MOTHER'S NAME (First, Middle, Maiden Surname) Amanda Newton King		
19a. INFORMANT'S NAME (Type/Print) Russell Clinton Wolfe										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1600 Dennis Ave., Towson, Maryland 21204		
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Riverside Cemetery				DATE JUN23		20c. LOCATION — City or Town, State Falmouth, Kentucky				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212		
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death 2 yrs 20 years		
<p>a.  Dementia DUE TO (OR AS A CONSEQUENCE OF):  ASCVD</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED				
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29c. LICENSE NUMBER D-74782		29d. DATE SIGNED (Month, Day, Year) ► JUNE 20, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James A. Quinlan, M.D. 7801 York Rd. Suite 100, Towson, Maryland 21204												
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 										

1

2

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

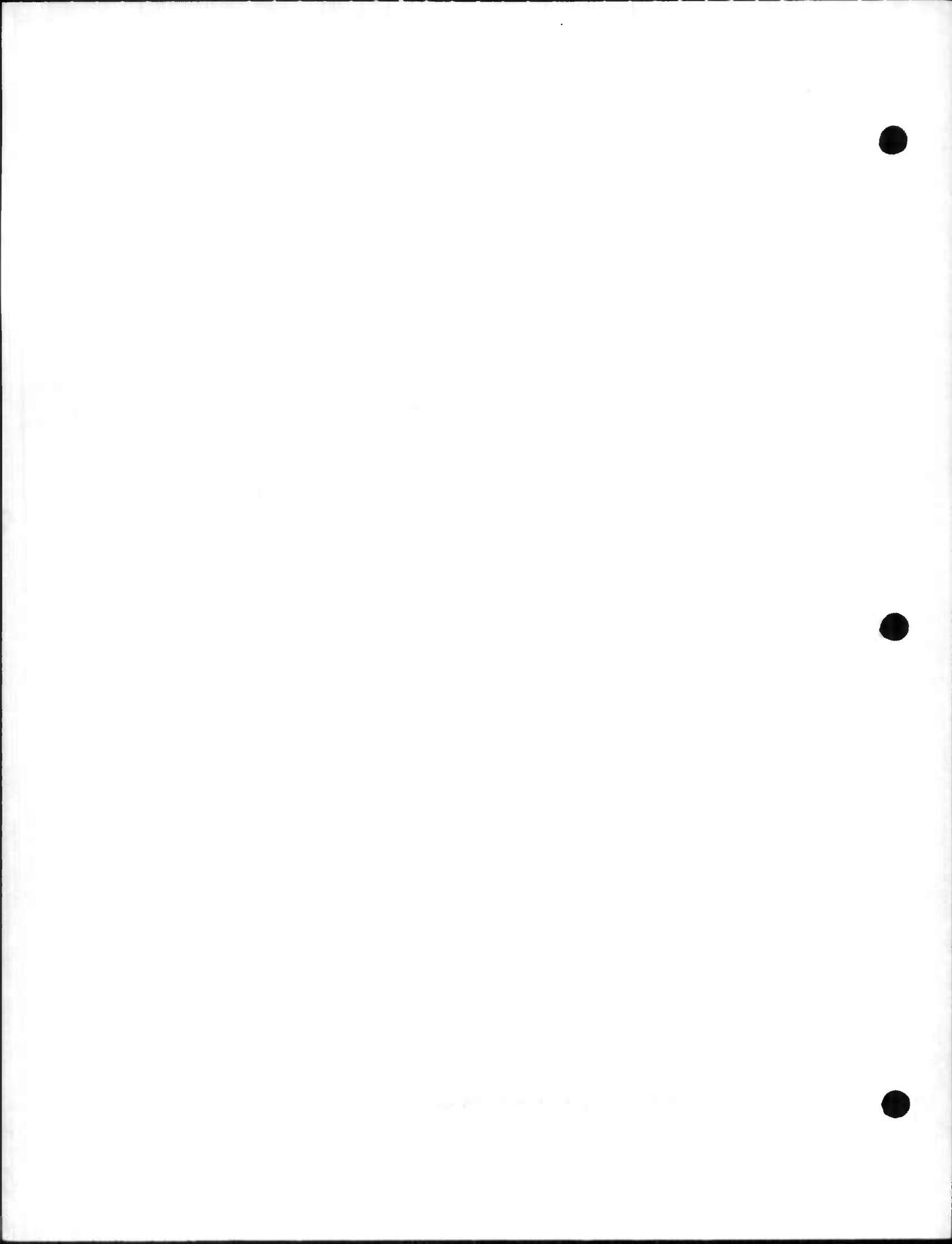
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) Louise E. Walton												2. DATE OF DEATH MONTH DAY YEAR June 24, 1995	3. TIME OF DEATH 3:38 A.M. M
4. SOCIAL SECURITY NUMBER 218-14-2643		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	7. DATE OF BIRTH (Month, Day, Year) Oct 28, 1922	8. BIRTHPLACE (State or Foreign Country) Maryland							
9a. FACILITY NAME (If not institution, give street and number) 830 Matthews Ave				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Anne Arundel					
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 830 Matthews Ave				10f. ZIP CODE 21225				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Home Maker		16b. KIND OF BUSINESS/INDUSTRY Own Home									
17. FATHER'S NAME (First, Middle, Last) Edwin Recker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Koenig									
19a. INFORMANT'S NAME (Type/Print) George F. Walton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 Matthews Ave, Baltimore, Maryland 21225									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Cedar Hill Cemetery				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery				DATE 6/26	20c. LOCATION — City or Town, State Baltimore, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Richard E Davis				22. NAME AND ADDRESS OF FACILITY Gonce Funeral Home 4001 Ritchie Highway, Balto, Md 21225									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 18 mos.	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>metastatic adenocarcinoma of colon</i> DUE TO (OR AS A CONSEQUENCE OF):													
b. _____ DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) D 22782											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29b. SIGNATURE AND TITLE OF CERTIFIER Am N Berkman MD		29c. LICENSE NUMBER D 22782				29d. DATE SIGNED (Month, Day, Year) ► 6/26/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Aron J. Berkman Harbor Hospital Center													
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Jebi Shuler-Parker											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 6 hours after death. Page 6 may be retained by the hospital or attending physician.

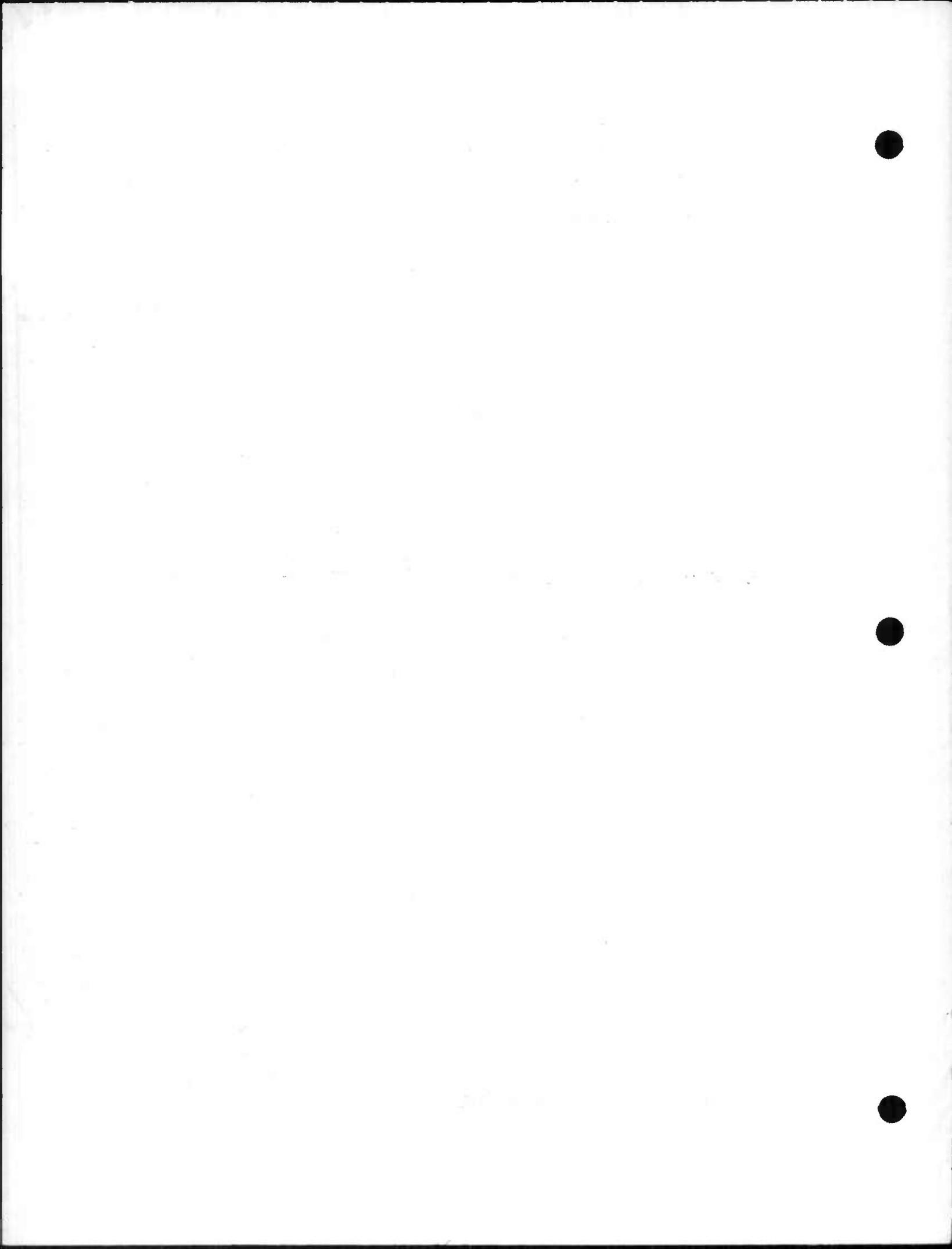
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR JUNE 23, 1995										3. TIME OF DEATH 1:13 P M		
t. DECEASED'S NAME (First, Middle, Last) EVELYN R. WACHTER												7. DATE OF BIRTH (Month, Day, Year) Dec. 20, 1930		8. BIRTHPLACE (State or Foreign Country) Maryland
4. SOCIAL SECURITY NUMBER 217 24 1761		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A		
RESIDENCE OF DECEASED												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10a. STATE Maryland	10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Baltimore								10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
10e. STREET AND NUMBER 10 Pebble Drive						10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Lab Technician				16b. KIND OF BUSINESS/INDUSTRY Glass Company								
17. FATHER'S NAME (First, Middle, Last) Lester Wachter		18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion J. Hoffman												
19a. INFORMANT'S NAME (Type/Print) Blanche Ramey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10 Pebble Drive Baltimore, Maryland 21225												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cem.				DATE 6/27		20c. LOCATION — City or Town, State Baltimore, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George J. Gonce		22. NAME AND ADDRESS OF FACILITY George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):												<1 wk.		
{ b. Pulmonary Angiopspasms DUE TO (OR AS A CONSEQUENCE OF):												8 yrs		
c. Squamous Cell Carcinoma of Left Lung DUE TO (OR AS A CONSEQUENCE OF): with bone metastasis												recently diagnosed 2 months		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: t <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				28d. DESCRIBE HOW INJURY OCCURRED								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? t <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER AS 2441614-22				29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARY JOELINE MINGOLO, M.D., Harbor Hospital Center 3001 South Hanover St. Baltimore, MD 21225														
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Jeanne Wilson												

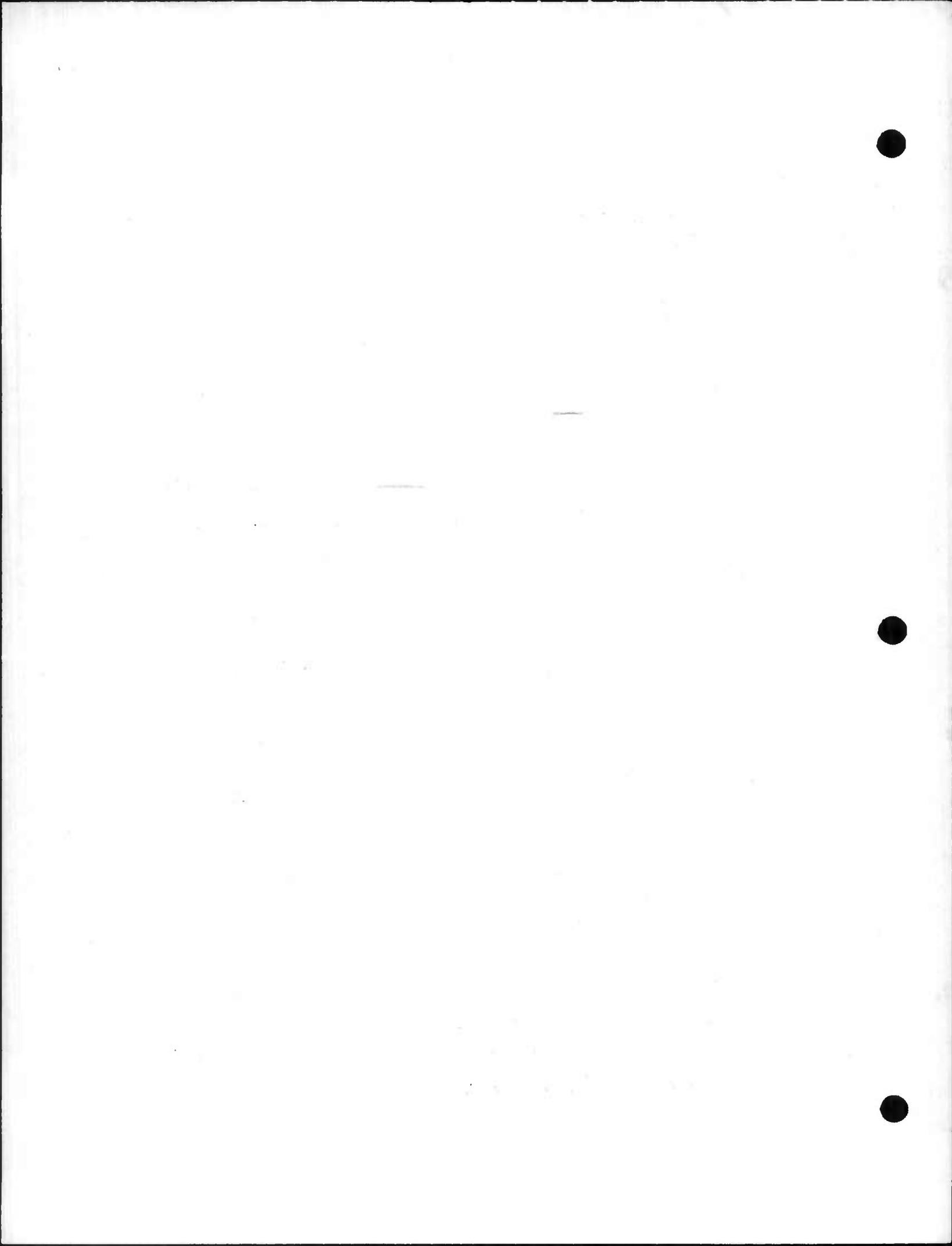


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1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GREGORY LANIAR WALLS, SR.				2. DATE OF DEATH MONTH DAY YEAR JUNE 23 1995	3. TIME OF DEATH 4:30 A.M.	
4. SOCIAL SECURITY NUMBER 212-58-4304		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 44 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) Jan 2, 1951	8. BIRTHPLACE (State or Foreign Country) Md
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A
RESIDENCE OF DECEDENT						
10a. STATE Md	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5523 Perdue Avenue				10f. ZIP CODE 21239	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 12th grade 4 yrs.			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black		14. RACE — American Indian, Black, White, etc. Specify:
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance Agent			16b. KIND OF BUSINESS/INDUSTRY Insurance Co.	
17. FATHER'S NAME (First, Middle, Last) Charles A. Walls, Sr				18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Beatrice Harding		
19a. INFORMANT'S NAME (Type/Print) Joyce E. Walls				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5523 Perdue Avenue Baltimore, Md 21239		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Uruguay Cemetery		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Uruguay Cemetery		DATE 62895	20c. LOCATION — City or Town, State Baltimore, Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gladyne Wanes				22. NAME AND ADDRESS OF FACILITY March F/H West 4300 Wabash Avenue Baltimore, Md 21215		
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only ONE cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Subarachnoid Hemorrhage DUE TO (OR AS A CONSEQUENCE OF): b. ruptured Berry aneurysm DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Approximate interval Onset and Death						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) At home		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28f. LOCATION (Street and Number or Rural Route Number, City or town, State)				
29b. SIGNATURE AND TITLE OF CERTIFIER Marion Lake, MD				29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marion Lake, MD 111 Penn Street, Baltimore, Maryland 21201						
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE Jane Shuler-Parkett				



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

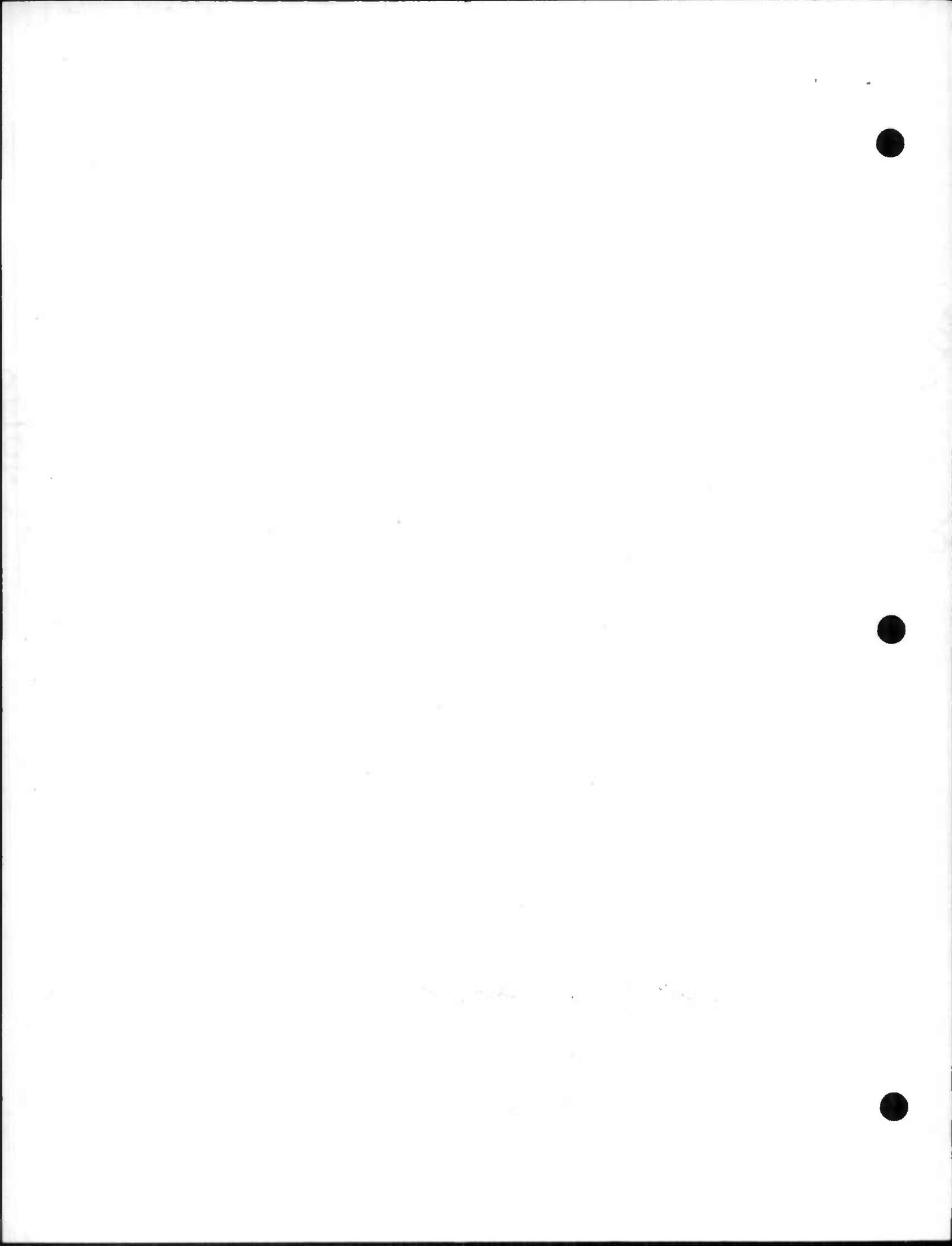
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR JUNE 21, 1995								3. TIME OF DEATH 16:09			
1. DECEASED'S NAME (First, Middle, Last) BETTY LEE WILSON										7. DATE OF BIRTH (Month, Day, Year) 2/14/31			
4. SOCIAL SECURITY NUMBER 218-26-0807		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 64 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			
9c. COUNTY OF DEATH													
RESIDENCE OF DECEASED													
10a. STATE Maryland	10b. COUNTY Carroll		10c. CITY, TOWN OR LOCATION Mt. Airy						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 309 N. Main Street										10f. ZIP CODE 21771	10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Her own home					
17. FATHER'S NAME (First, Middle, Last) Harry Bingman, Sr.										18. MOTHER'S NAME (First, Middle, Maiden Surname) Martha Norwood			
19a. INFORMANT'S NAME (Type/Print) Mr. Harry Bingman, Jr.										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1028 Elm Road Baltimore, MD 21227			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) Prospect U.M. Church Cemetery				DATE 6/26/95	20c. LOCATION — City or Town, State Mt. Airy, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Evans</i>					22. NAME AND ADDRESS OF FACILITY Burrier-Queen Funeral Directors, P.A. 1212 W. Old Liberty Road Winfield, MD 21784								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. <u>Sepsis</u> DUE TO (OR AS A CONSEQUENCE OF):													
b. <u>Endocarditis</u> DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>End stage renal disease</u>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED					
		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Diane Dorinsky, MD</i>										29c. LICENSE NUMBER L7712	29d. DATE SIGNED (Month, Day, Year) June 21, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Johns Hopkins Hospital, 600 W. Wolfe Street, Baltimore, Maryland 21287										31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE <i>Jeanne Anderson Park</i>	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

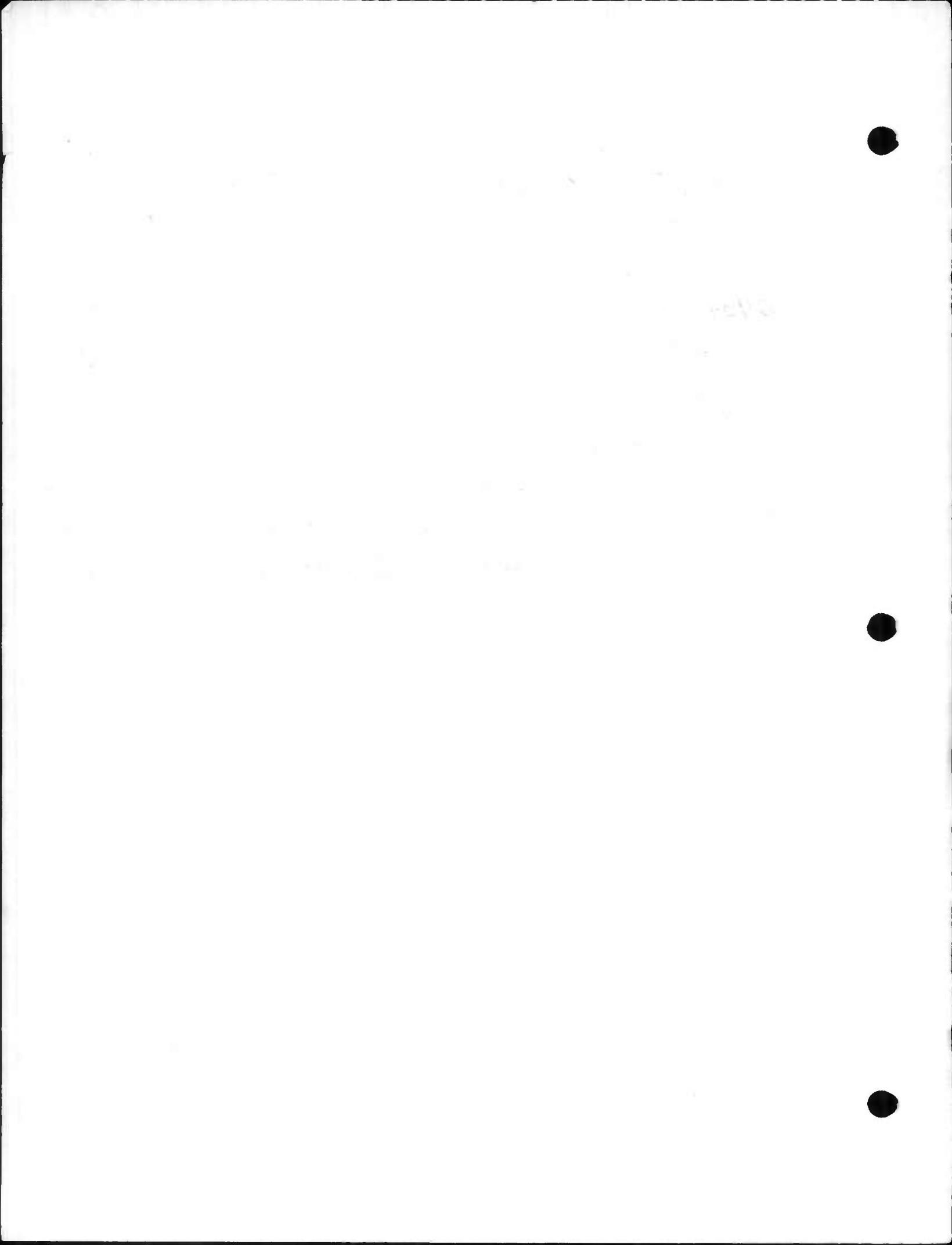
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, clemation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - FOR STATE REGISTRAR																		
1. DECEASED'S NAME (First, Middle, Last)													2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH			
<i>Virgil Williams</i>													June 29 1995		730 A.M.			
4. SOCIAL SECURITY NUMBER			5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH Month Day Year		8. BIRTHPLACE (State or Foreign Country)					
238-20-5098			1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		74 YRS.		MONTHS		DAYS		HOURS		MIN.					
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH												9c. COUNTY OF DEATH			
LEVINDALE NURSING HOME			BALTIMORE												N/A			
RESIDENCE OF DECEASED			10c. CITY, TOWN OR LOCATION												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STATE MD.			10b. COUNTY N/A		Baltimore													
10e. STREET AND NUMBER 2434 W. BELVEDERE AVE.					10f. ZIP CODE 21215								10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black									
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY own home												
17. FATHER'S NAME (First, Middle, Last) UNKNOWN			18. MOTHER'S NAME (First, Middle, Maiden Surname) UNKNOWN															
19a. INFORMANT'S NAME (Type/Print) ARTHUR DRAGER - ATTORNEY			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5 LIGHT ST. SUITE 510 BALTO., MD. 21202															
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEM. 6-22-95			DATE			20c. LOCATION — City or Town, State BALTO. CO. MD.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phoma J. Shadley</i>			22. NAME AND ADDRESS OF FACILITY SKARDA FH 2829 HODSON ST. BALTO., MD. 21224															
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death ≈ 1 year					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>																		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____													24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
													24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED						
												28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						
												28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Virgil Williams Physician</i>			29c. LICENSE NUMBER D448A			29d. DATE SIGNED (Month, Day, Year) June 29 1995												
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RUNIL P. RATANI 2434 W. Belvedere Ave., Baltimore, MD																		
31. DATE FILED (Month, Day, Year) JUN 26 1995			32. REGISTRAR'S SIGNATURE <i>John Shadley</i>															



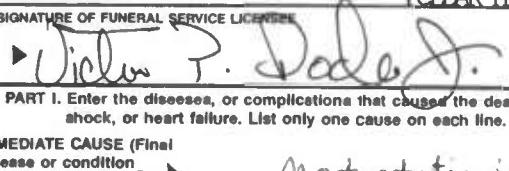
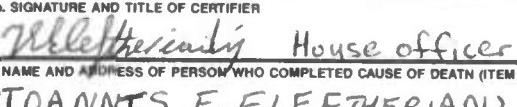
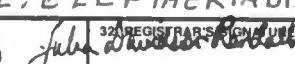
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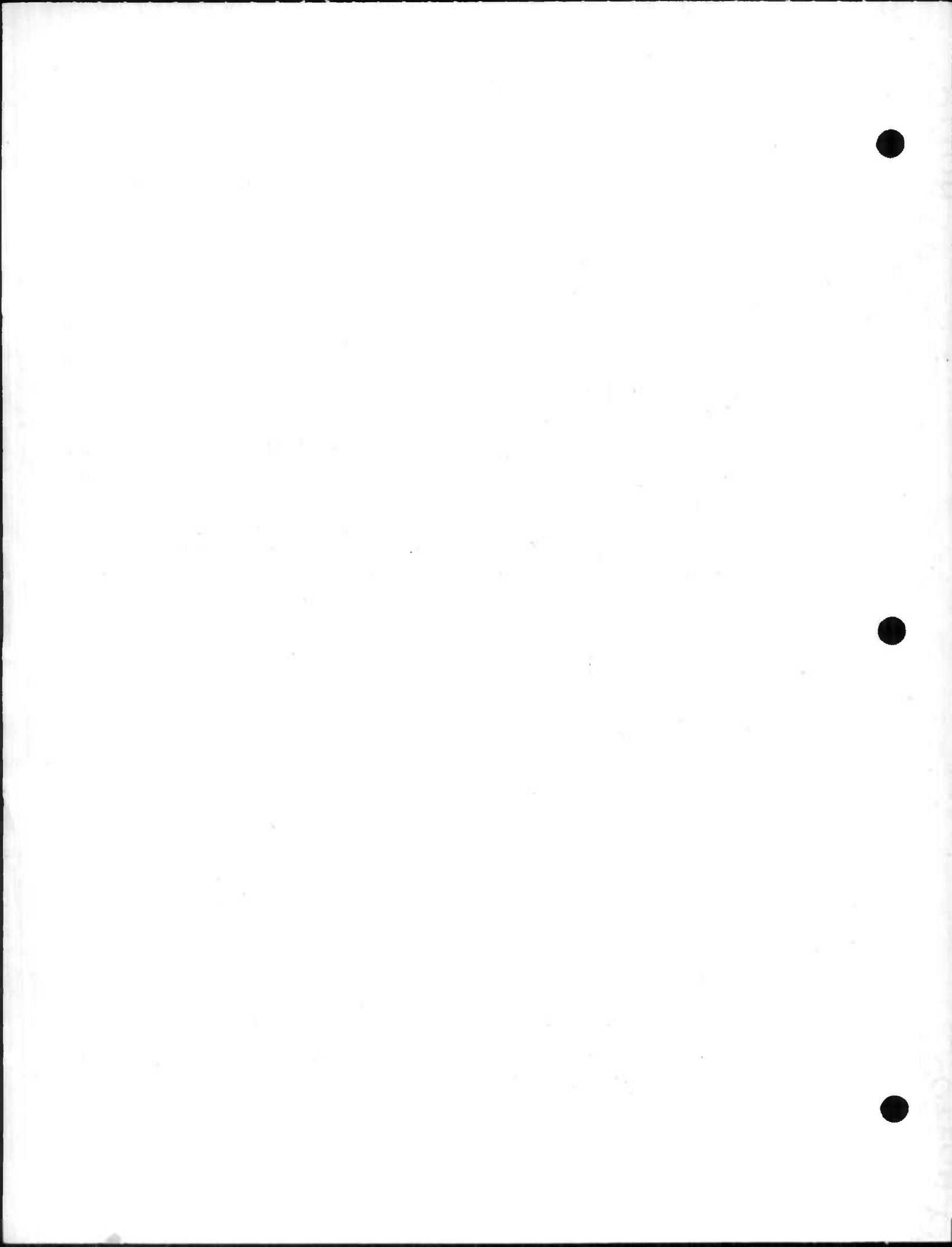
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)			ANNA BURNETTA WYJEK						2. DATE OF DEATH MONTH DAY YEAR			3. TIME OF DEATH			
4. SOCIAL SECURITY NUMBER 215-18-6648			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTHN (Month, Day, Year) FEBRUARY 9 1922			8. BIRTHPLACE (State or Foreign Country) MD	
9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL CENTER			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE						9c. COUNTY OF DEATH BALTIMORE						
10a. STATE MD			10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 1431 WOODALL STREET			10f. ZIP CODE 21230						10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9th			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) N/A			16b. KIND OF BUSINESS/INDUSTRY FEDERAL EMPLOYEE			SOCIAL SECURITY						
17. FATHER'S NAME (First, Middle, Last) LOUIS SMITH			18. MOTHER'S NAME (First, Middle, Maiden Surname) GRACE NASH												
19a. INFORMANT'S NAME (Type/Print) SHARON A. MARKEY			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1644 E. FORT AVENUE, BALTIMORE, MD 21230												
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) CEDAR HILL CEMETERY, JUNE 28, 1995			DATE			20c. LOCATION — City or Town, State MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY CHARLES L. STEVENS FUNERAL HOME, INC. 1501 E. FORT AVENUE, BALTIMORE, MD 21230												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Approximate Interval Between Onset and Death			
a. Metastatic infiltrating ductal carcinoma to pleura & chest wall DUE TO (OR AS A CONSEQUENCE OF): 2½ yrs															
b. _____ DUE TO (OR AS A CONSEQUENCE OF):															
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Trousseau's Syndrome															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. DESCRIBE HOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  IOANNIS E. ELEFTHERIADIS										29c. LICENSE NUMBER AS244161451			
												29d. DATE SIGNED (Month, Day, Year) ►JUNE 25, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) IOANNIS E. ELEFTHERIADIS		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3001 South Hanover St. Baltimore Md 21225													
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 													



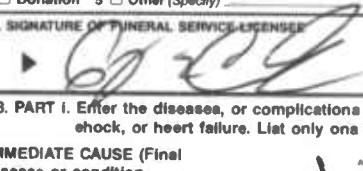
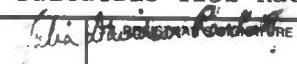
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

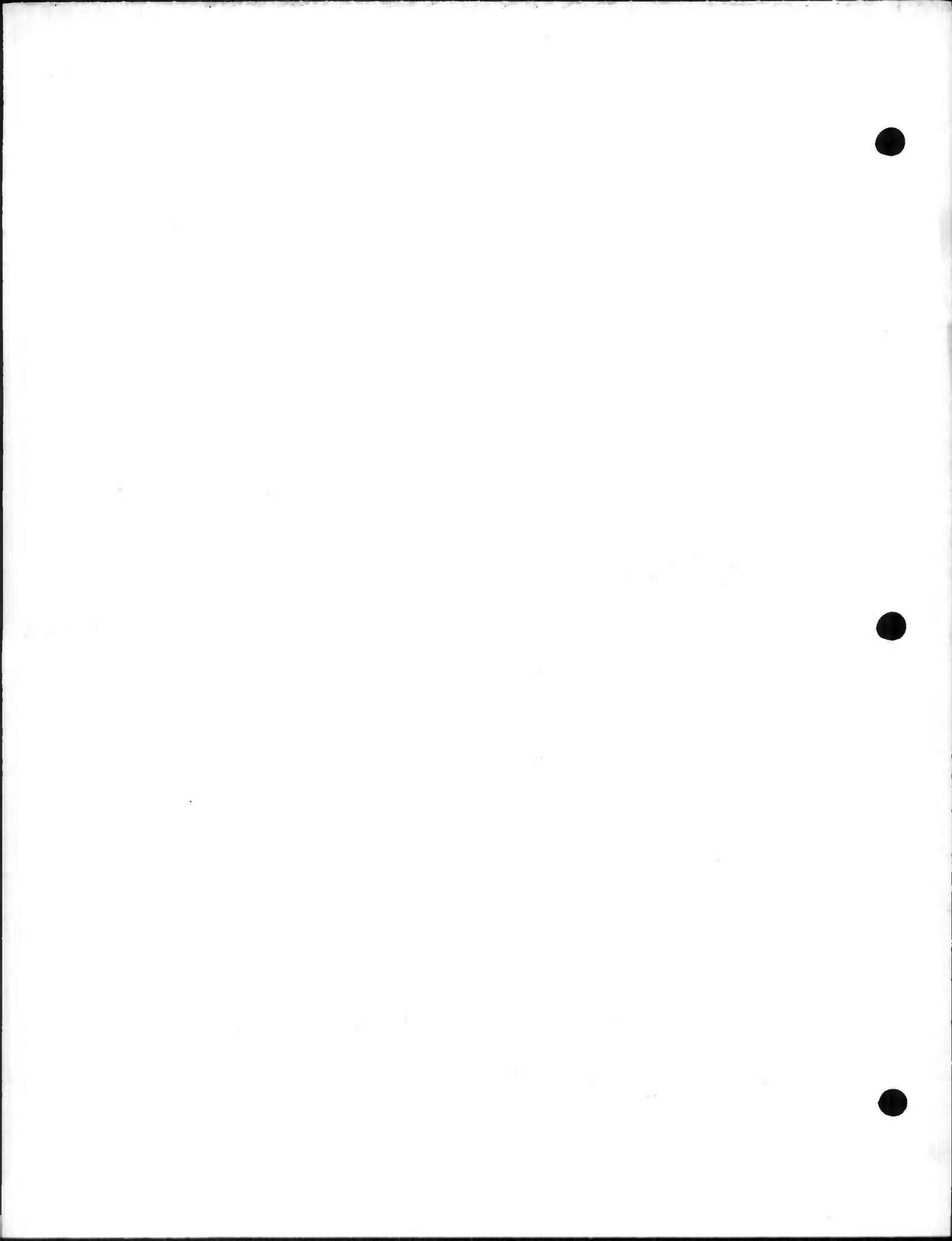
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

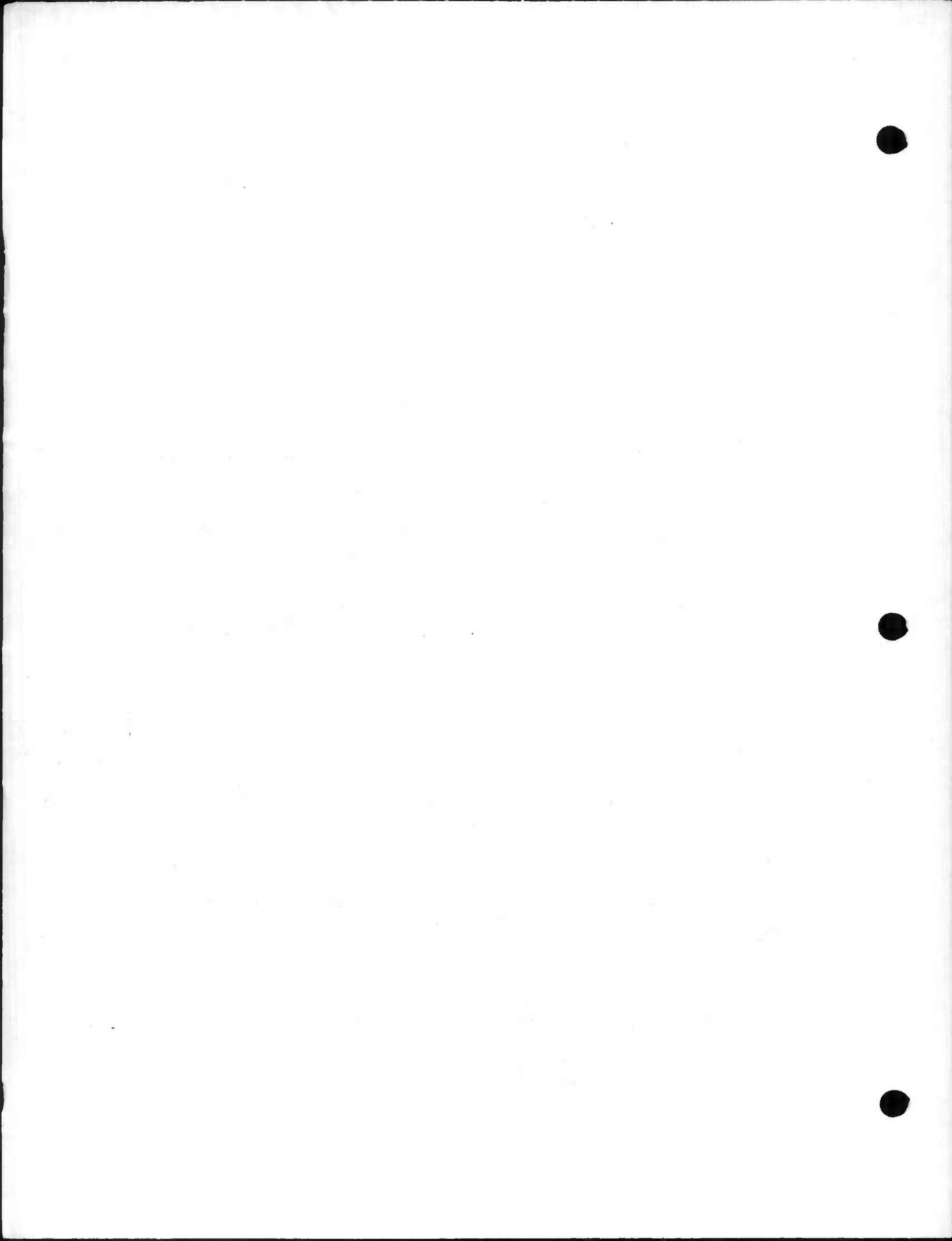
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Victoria WITKOWSKI											2. DATE OF DEATH MONTH DAY YEAR JUNE 22 1995	3. TIME OF DEATH 11:58 a^m
4. SOCIAL SECURITY NUMBER 214224375		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC 22, 1912	8. BIRTHPLACE (State or Foreign Country) MARYLAND					
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN WOODS			9b. CITY, TOWN OR LOCATION OF DEATH ROSEDALE			9c. COUNTY OF DEATH BALTIMORE						
10e. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET ADDRESS 919 FROG MORTAR ROAD				10f. ZIP CODE 21220			10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 4			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0 HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY OWN HOME							
17. FATHER'S NAME (First, Middle, Last) JOSEPH ROTH					18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCES ROTH							
19a. INFORMANT'S NAME (Type/Print) JOSEPH E. WITKOWSKI				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 919 FROG MORTAR ROAD BALTIMORE, MD 21220								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HOLLY HILLS			DATE 6/24	20c. LOCATION — City or Town, State BALTIMORE, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVE. BALTIMORE, MD 21237								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death 4 months	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver Failure DUE TO (OR AS A CONSEQUENCE OF): b. Metastatic Colonic Ca to Liver. DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER P.A. Baltatzis, M.D.											29c. LICENSE NUMBER D 28949	29d. DATE SIGNED (Month, Day, Year) ► 6-22-1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) Type, Print Dr. Panayiotis Baltatzis 1232 Race Road Suite 202 Baltimore, Maryland 21237												
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. APPROVAL SIGNATURE 										



FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		WESLEY				2. DATE OF DEATH MONTH JUNE DAY 6 YEAR 95	3. TIME OF DEATH 9:37 PM
DARRNEL						7. DATE OF BIRTH (Month, Day, Year) 2-29-59	
4. SOCIAL SECURITY NUMBER 216-78-2385		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 1837 E. EAGER STREET		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEASED 10a. STATE Maryland		10b. COUNTY NA	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 229 North Madera Street		10f. ZIP CODE 21231				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Kitchen Help				14. RACE — American Indian, Black, White, etc. Specify: Black	
17. FATHER'S NAME (First, Middle, Last) Freddie Wesley		18. MOTHER'S NAME (First, Middle, Maiden Surname) Sadie Wilson					
19a. INFORMANT'S NAME (Type/Print) Sadie Wesley		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 951 Wolfe Street Baltimore Maryland					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory 6-22-95				DATE	20c. LOCATION — City or Town, State Catonville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Jeff Miller Funeral Home PC 21213					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Blunt Force Injuries to the Head DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) AT SCENE				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) One	28b. TIME OF INJURY JK M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED Subcut blaster		
28e. PLACE OF INJURY building, etc. (Specify) Death House		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1837 E. Eager St.					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER O.C.M.E.				29d. DATE SIGNED (Month, Day, Year) JUNE 7, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ST ALAN LOCKE, MD 111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

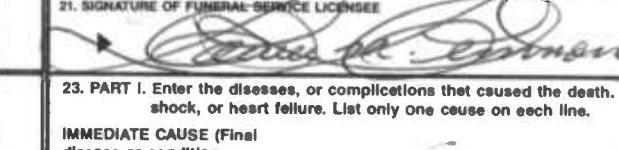
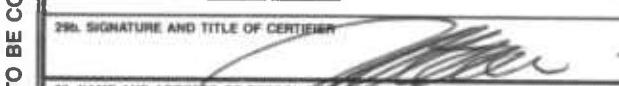
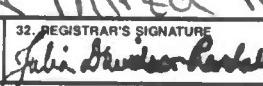
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Frances Louise White										2. DATE OF DEATH MONTH DAY YEAR June 19, 1995	3. TIME OF DEATH 9:45 A.M.	
4. SOCIAL SECURITY NUMBER 578-03-1164		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sep. 29, 1911		8. BIRTHPLACE (State or Foreign Country) Bramwell, W. VA.		
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH -----				
10a. STATE S. Carolina		10b. COUNTY ---		10c. CITY, TOWN OR LOCATION N. Myrtle Beach				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 2406 Causey Drive				10f. ZIP CODE 29582				10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES -----				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: -----				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Secretary				16b. KIND OF BUSINESS/INDUSTRY Architectural Industry						
17. FATHER'S NAME (First, Middle, Last) Pleasant Byrd Thomas						18. MOTHER'S NAME (First, Middle, Maiden Surname) Wyle Esther Hancock						
19a. INFORMANT'S NAME (Type/Print) Mrs. Esther L. Fedner						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 200 Wickersham Way, Cockeysville, Md. 21030						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Fairview Cemetery				DATE 6/22/95		20c. LOCATION — City or Town, State Roanoke, Va.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 											22. NAME AND ADDRESS OF FACILITY Lemmon Funeral Home	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →											Approximate Interval Between Onset and Death >5yr	
<p>a. Congestive Heart Failure</p> <p>b. Ischemic Heart Disease</p> <p>c. Valvular Heart Disease</p> <p>d. Type II Diabetes Mellitus</p>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Polyuria, Polydipsia, Polyphagia, Weight loss, Dry skin, etc.											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 041901				29d. DATE SIGNED (Month, Day, Year) ► 6-20-95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Zia S. Mirza MD - 3007 E Northern Parkway, Baltimore, MD												
31. DATE FILED (Month, Day, Year) JUN 26 1995		32. REGISTRAR'S SIGNATURE 										

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

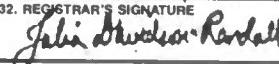
TO BE COMPLETED BY FUNERAL DIRECTOR

FilmG, 724, item #1, 6/26/95, cyw, per f.h.

95 19328

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Eileen MARY WEBSTER				2. DATE OF DEATH MONTH DAY YEAR June 20, 1995				3. TIME OF DEATH 9:16 P M				
4. SOCIAL SECURITY NUMBER 220-50-2350		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 10, 1908		8. BIRTHPLACE (State or Foreign Country) Ireland				
9a. FACILITY NAME (If not Institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville				9c. COUNTY OF DEATH Baltimore				
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Dundalk				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
10e. STREET AND NUMBER 2367 Searles Road				10f. ZIP CODE 21222				10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify:				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) William Joseph Ennis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Kathleen Therese Byron								
19a. INFORMANT'S NAME (Type/Print) Mrs. Kathleen C. Gray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2367 Searles Road Baltimore, Maryland 21222								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) New Cathedral Cemetery 6/23/95			20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Duda-Ruck Funeral Home of Dundalk, Inc. 7922 Wise Ave. Dundalk, Maryland 21222								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. Cardiac Arrhythmia OUE TO (OR AS A CONSEQUENCE OF): c. Arteriosclerotic heart disease OUE TO (OR AS A CONSEQUENCE OF): d. OUE TO (OR AS A CONSEQUENCE OF):										minutes		
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										years		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month, Day, Year)  June 21, 1995		
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D13664								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) B.C. VENERACION JR M.D. 1576 MERRIT BLVD STE 22 BALTO MD 21222										OHMH-16 Rev 1/89		
31. DATE FILED (Month, Day, Year) JUN 26 1995				32. REGISTRAR'S SIGNATURE 								

2 - 1000000000

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

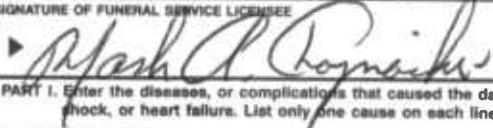
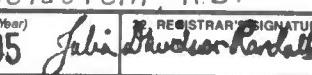
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

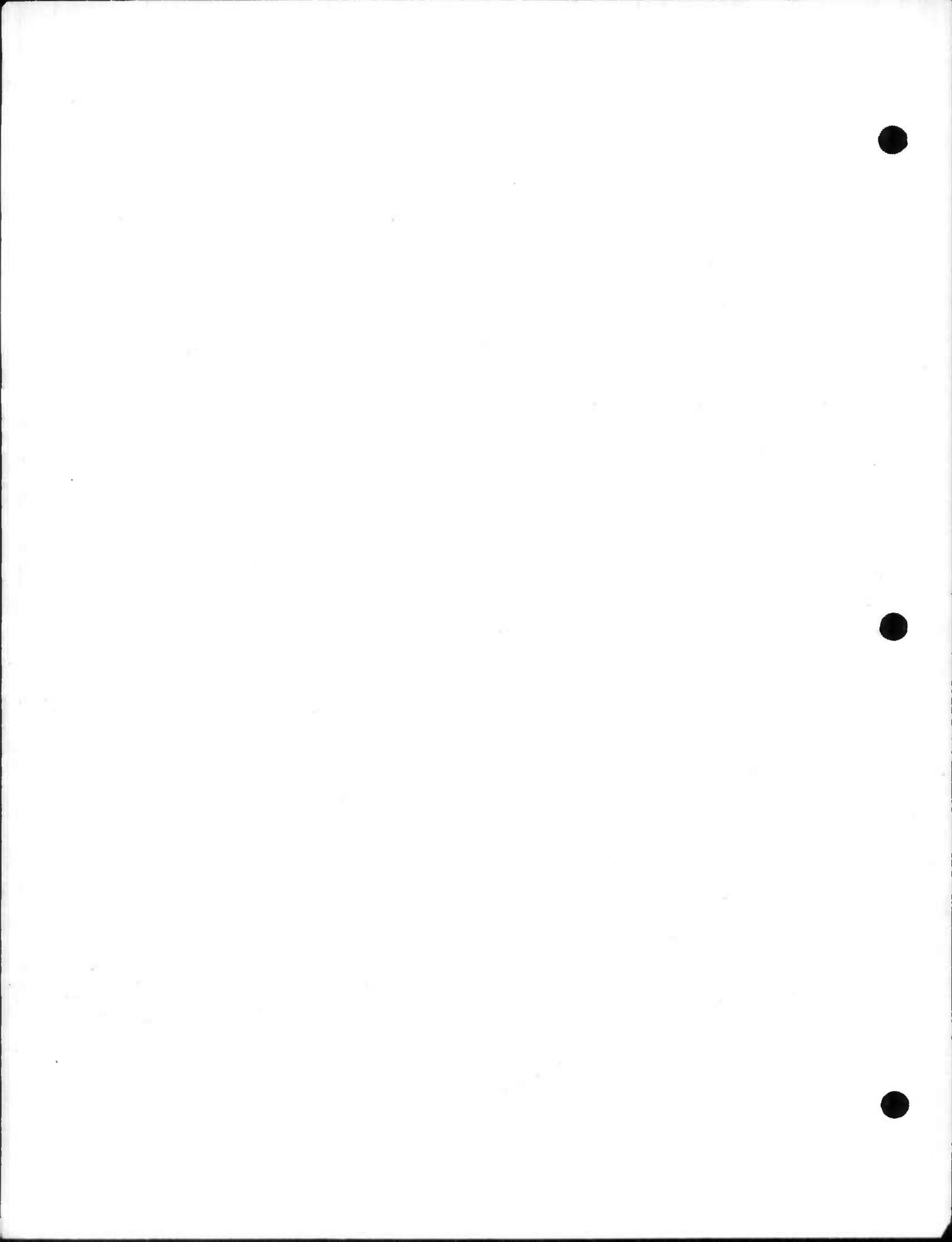
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH June DAY 23, 1995 YEAR	3. TIME OF DEATH 3:15 p.m.
Lewis D. Almond Jr.										7. DATE OF BIRTH (Month Day Year) July 19 31	8. BIRTHPLACE (State or Foreign Country) Maryland
4. SOCIAL SECURITY NUMBER 224-36-2604		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Bayview										9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	9c. COUNTY OF DEATH NA
RESIDENCE OF DECEDENT											
10e. STATE Maryland	10b. COUNTY NA	10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER Boston Street 6311										10f. ZIP CODE 21224	10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1949 to 1955		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) NA		16b. KIND OF BUSINESS/INDUSTRY Coil Pack				Steel			
17. FATHER'S NAME (First, Middle, Last) Lewis D. Almond Sr.										18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose M. Coppage	
19e. INFORMANT'S NAME (Type/Print) Oscar Almond										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Thaxton Pl. 11001 Fredericksburg, Va. 22407	
20e. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, sepulture, etc.) Greenmount		DATE June 26		20c. LOCATION — City or Town, State Baltimore, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY W. Dabrowski/Chojnacki F.H. P.A. 1005 Dundalk Ave. Balto., Md. 21224	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. End-Stage Liver Disease DUE TO (OR AS A CONSEQUENCE OF):										years	
b. Metastatic Gastric cancer with brain mets DUE TO (OR AS A CONSEQUENCE OF):										months	
c. Aspiration Pneumonia DUE TO (OR AS A CONSEQUENCE OF):										1 day	
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER  Daniel R. Goldstein, M.D.		29c. LICENSE NUMBER 94003		29d. DATE SIGNED (Month, Day, Year) ► June 26, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JUN 27 1995 		Johns Hopkins Bayview Medical Center 4940 Eastern Avenue Baltimore, MD 21224									
31. DATE FILED (Month, Day, Year)		REGISTRAR'S SIGNATURE									



95 19330

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PHILLIP ARMSTRONG												2. DATE OF DEATH MONTH JUNE DAY 21 YEAR 1995	3. TIME OF DEATH 12:15 P.M.
4. SOCIAL SECURITY NUMBER 220-64-5557		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 39 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1/11/1956			8. BIRTHPLACE (State or Foreign) Baltimore, Baltimore, MD.				
9a. FACILITY NAME (If not institution, give street and number) 221 FREMONT AVENUE		APT. 1408		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH n/a						
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE MARYLAND	10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE			10f. ZIP CODE 21217			10g. CITIZEN OF WHAT COUNTRY? USA				
10e. STREET AND NUMBER 221 N. FREMONT AVENUE		10f. ZIP CODE APT. 1408		10g. CITIZEN OF WHAT COUNTRY? USA			11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Black		
14. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		15. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) n/a		16. KIND OF BUSINESS/INDUSTRY n/a									
17. FATHER'S NAME (First, Middle, Last) Chester Epps				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mackie Armstrong									
19a. INFORMANT'S NAME (Type/Print) Roberta Mason				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 514 N. East Avenue Baltimore, MD 21205									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE 6/24		20c. LOCATION — City or Town, State Catonsville, MD							
21. SIGNATURE OF FUNERAL SERVICE CLERK/SEE LEROY O. DYETT				22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, stroke, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death)													
a. ACUTE NARCOTIC INTOXICATION DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) FOUND 6-21-95		28b. TIME OF INJURY (Hour, Minutes) 12:10 P.M.	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND AT HOME		29f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 221 FREMONT AVE. BALTIMORE, MARYLAND											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD		29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Julin Shuler-Rodell											

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

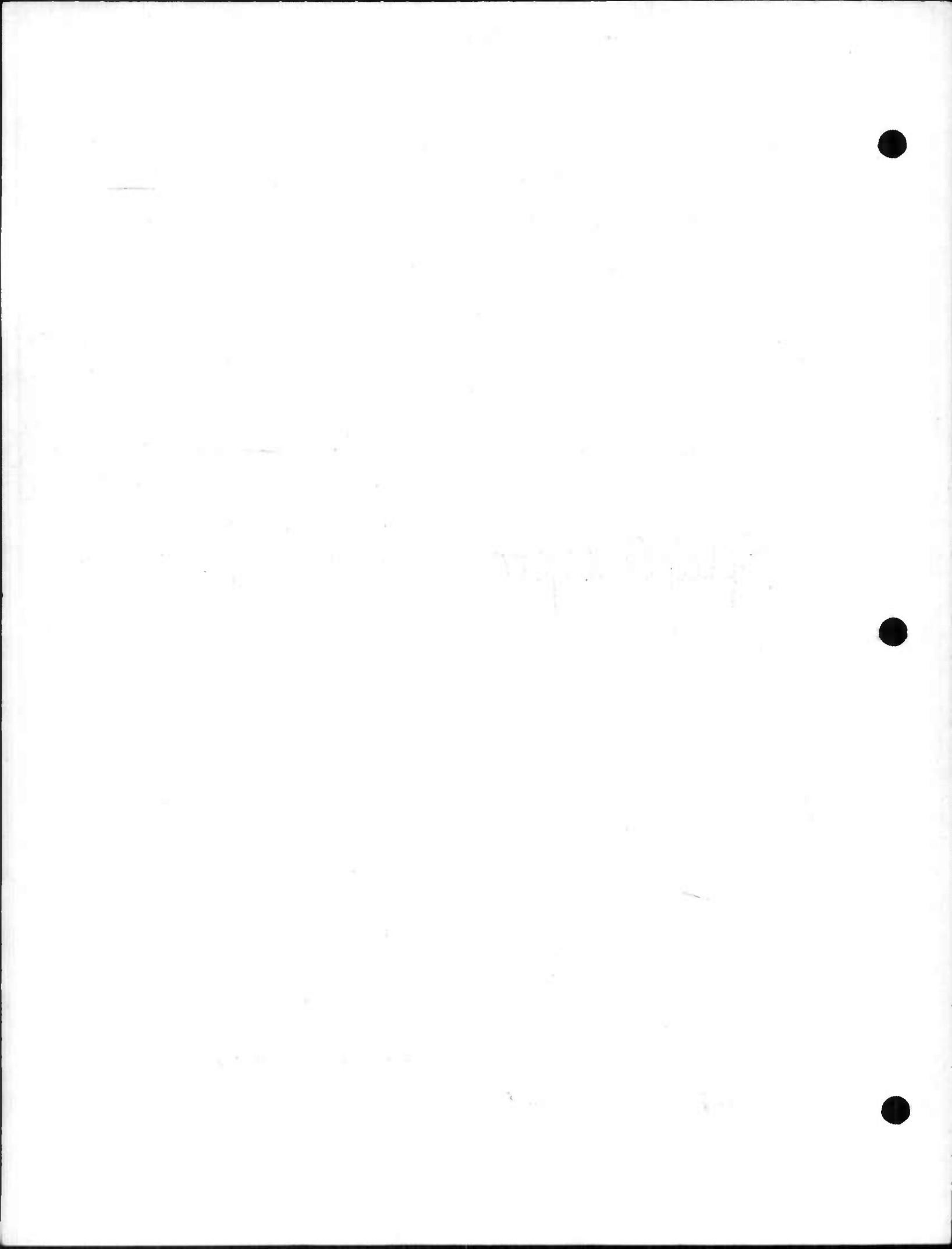
TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

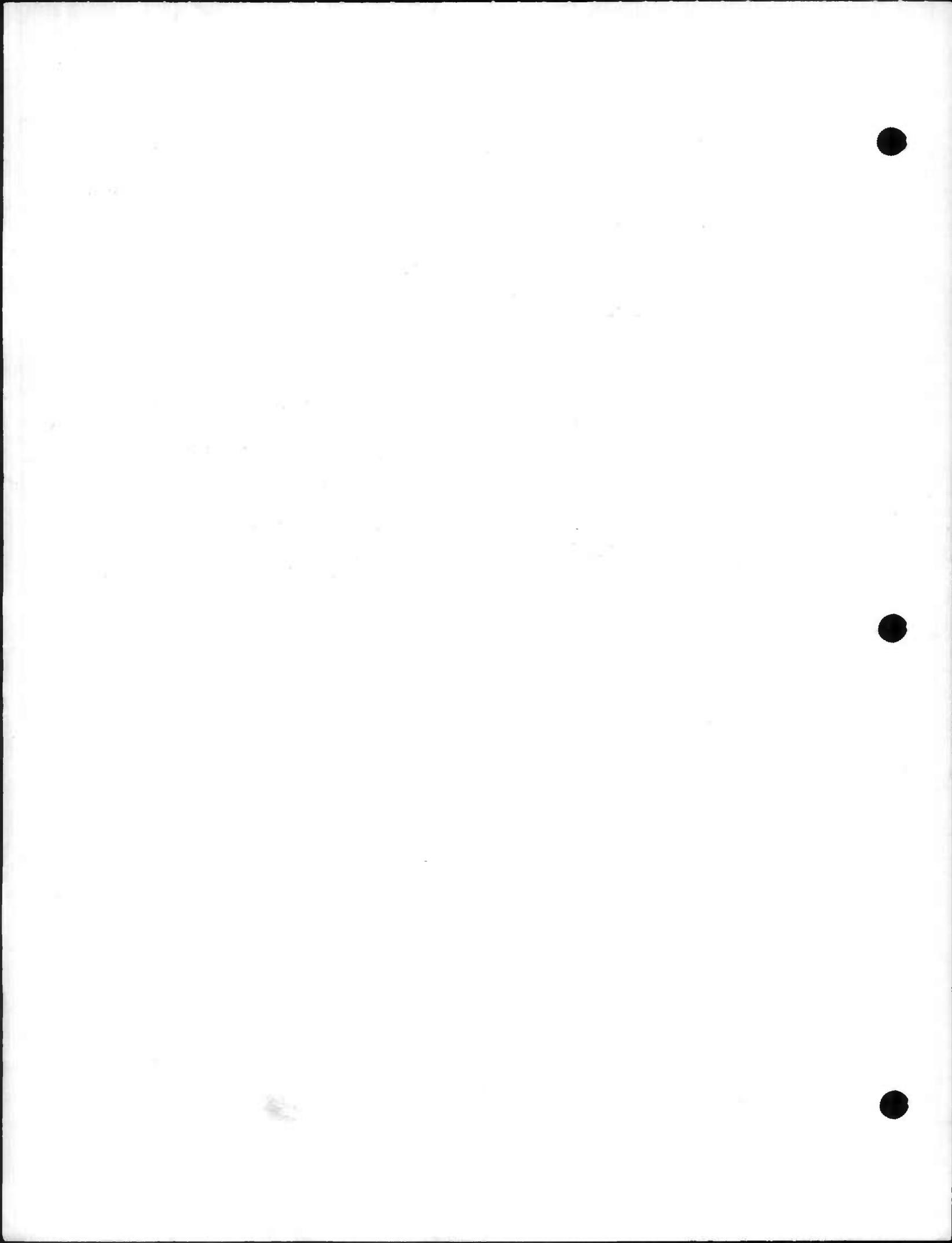
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH JUNE DAY 25 YEAR 1995	3. TIME OF DEATH 1:55 PM	
LILLIAN MARY ANDRZEJEWSKI										7. DATE OF BIRTH (Month, Day, Year) DEC 10, 1904		8. BIRTHPLACE (State or Foreign Country) MARYLAND
4. SOCIAL SECURITY NUMBER 217094061		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.					
9a. FACILITY NAME (If not institution, give street and number) DULANEY VALLEY NURSING										9b. CITY, TOWN OR LOCATION OF DEATH TOWSON	9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT												
10e. STATE MD	10b. COUNTY BALTIMORE	10c. CITY, TOWN OR LOCATION TOWSON								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 111 WEST ROAD										10f. ZIP CODE 21204	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:					14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0			16b. KIND OF BUSINESS/INDUSTRY WAITRESS					FOOD SERVICE		
17. FATHER'S NAME (First, Middle, Last) CHARLES HRDLICKA										18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY KOZLOWSKI		
19a. INFORMANT'S NAME (Type/Print) GERALDINE CHELF										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 RASPBERRY CT BALTIMORE, MD 21220		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORIUM			DATE 6/26	20c. LOCATION — City or Town, State BALTIMORE, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY CVACH/ROSEDALE FUNERAL HOME 1211 CHESACO AVENUE BALTO. MD 21237		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death 1 MO		
a. CONGENITAL HEART FAILURE												
b. DUE TO (OR AS A CONSEQUENCE OF): CHRONIC ISCHEMIC HEART DISEASE										YEARS		
c. DUE TO (OR AS A CONSEQUENCE OF):												
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ARRHYTHMIA MITRAL STENOSIS										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4 <input type="checkbox"/>										
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> HO		28d. DESCRIBE HOW INJURY OCCURRED				
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Eva S. Hersh M.D. (PHYSICIAN)		29c. LICENSE NUMBER D36581		29d. DATE SIGNED (Month, Day, Year) ► 6/26/95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eva S. Hersh, M.D. EVA S. HERSH, 14N S. CHARLES ST.												
31. DATE FILED (Month, Day, Year) 6-JUN-95		32. REGISTRAR'S SIGNATURE John J. Kelleher										



FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

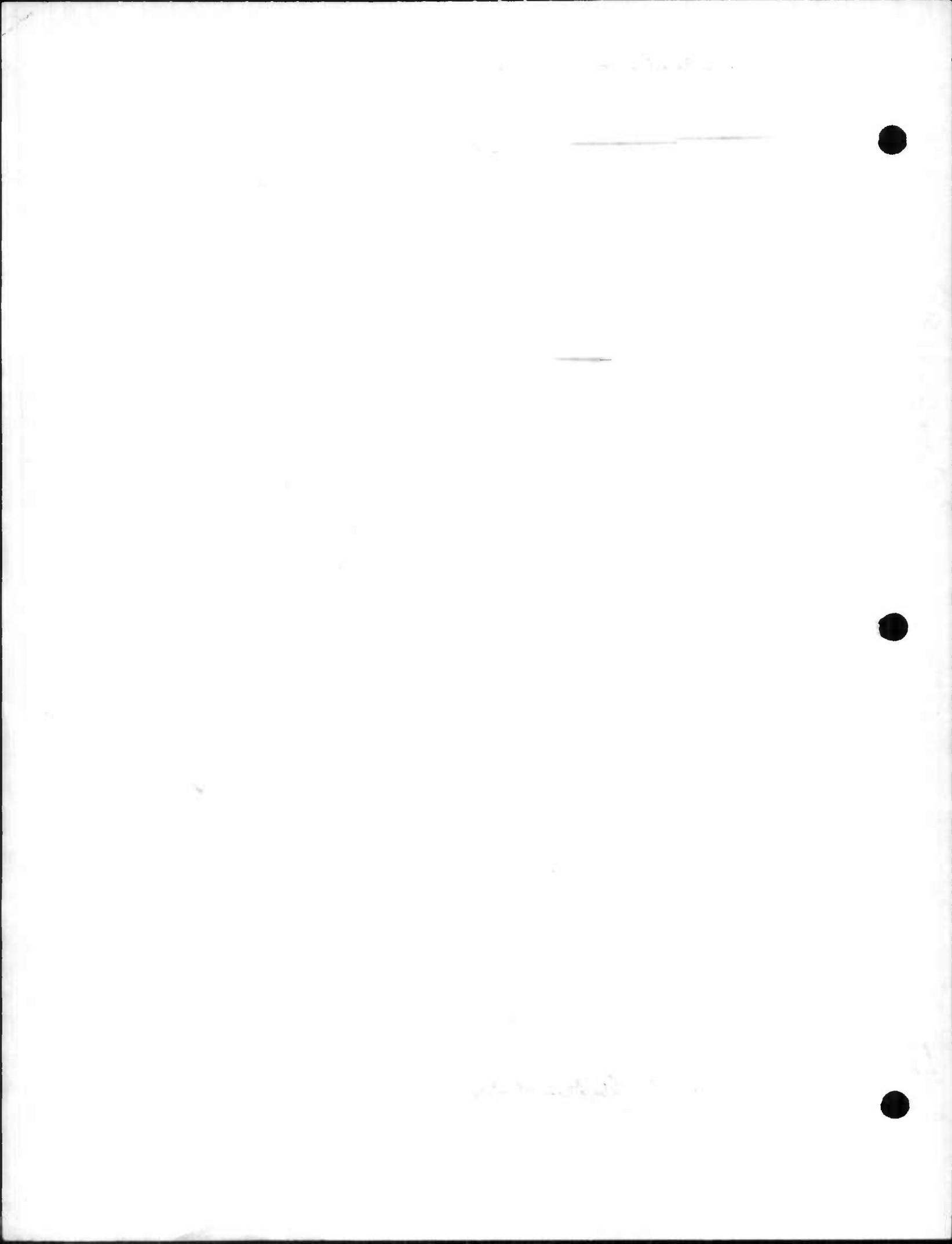
1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH 6 DAY 22 YEAR 95				3. TIME OF DEATH 5:55 PM												
<u>BAKER HARVEY</u> HARVEY CLAYTON BAKER																		
4. SOCIAL SECURITY NUMBER <u>215-28-7530</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>63</u> YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <u>7/20/1931</u>	8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>											
9a. FACILITY NAME (If not institution, give street and number) <u>Baltimore VAMC</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>				9c. COUNTY OF DEATH <u>N/A</u>												
10a. STATE <u>Maryland</u>		10b. COUNTY <u>N/A</u>	10c. CITY, TOWN OR LOCATION <u>Baltimore</u>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO												
10e. STREET AND NUMBER <u>3320 Elmora Avenue</u>		10f. ZIP CODE <u>21213</u>			10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>													
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <u>1951</u> IF YES, GIVE WAR OR DATES <u>WW II Korean Conflict</u>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> Specify: <u>X</u>		14. RACE — American Indian, Black, White, etc. <u>White</u>												
15. DECEASED'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (0-12) 12</u>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) <u>Printer</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Printing Industry</u>														
17. FATHER'S NAME (First, Middle, Last) <u>Earl Clayton Baker</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Ethel Wilson</u>																
19a. INFORMANT'S NAME (Type/Print) <u>Linda Baker</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3320 Elmora Avenue Baltimore, MD 21213</u>																
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>Metro Crematory, Inc.</u>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>06/27/95</u>		DATE	20c. LOCATION — City or Town, State <u>Baltimore, MD</u>													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Dawn F. McDonald</u>		22. NAME AND ADDRESS OF FACILITY <u>Cremation Society of Maryland, Inc.</u>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Intra cranial hemorrhage</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____ Approximate Interval Between Onset and Death <u>12 hrs.</u>														
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sepsis, renal failure, cardiac ischemia,</u>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Hospital: <u>1 Inpatient</u> <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Other: <u>4 Nursing Home</u> <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <table border="1"><tr><td><input checked="" type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td></td></tr><tr><td><input type="checkbox"/> Suicide</td><td><input type="checkbox"/> Could not be determined</td></tr><tr><td><input type="checkbox"/> Homicide</td><td></td></tr></table>			<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <u>8/22/95</u>	28b. TIME OF INJURY M <u>1</u> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED <u>At home, farm, street, factory, office building, etc. (Specify)</u>
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																	
<input type="checkbox"/> Accident																		
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																	
<input type="checkbox"/> Homicide																		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>Gregory A Bishop MD</u>		29c. LICENSE NUMBER <u>P08655</u>	29d. DATE SIGNED (Month, Day, Year) <u>6/22/95</u>													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>University of Maryland Hospital, 225 Greene St., Balt. Md. 21201</u>		31. DATE FILED (Month, Day, Year) <u>6/27/95</u>		32. REGISTRAR'S SIGNATURE <u>Jeanne R. Rodell</u>														

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

5 + 1

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

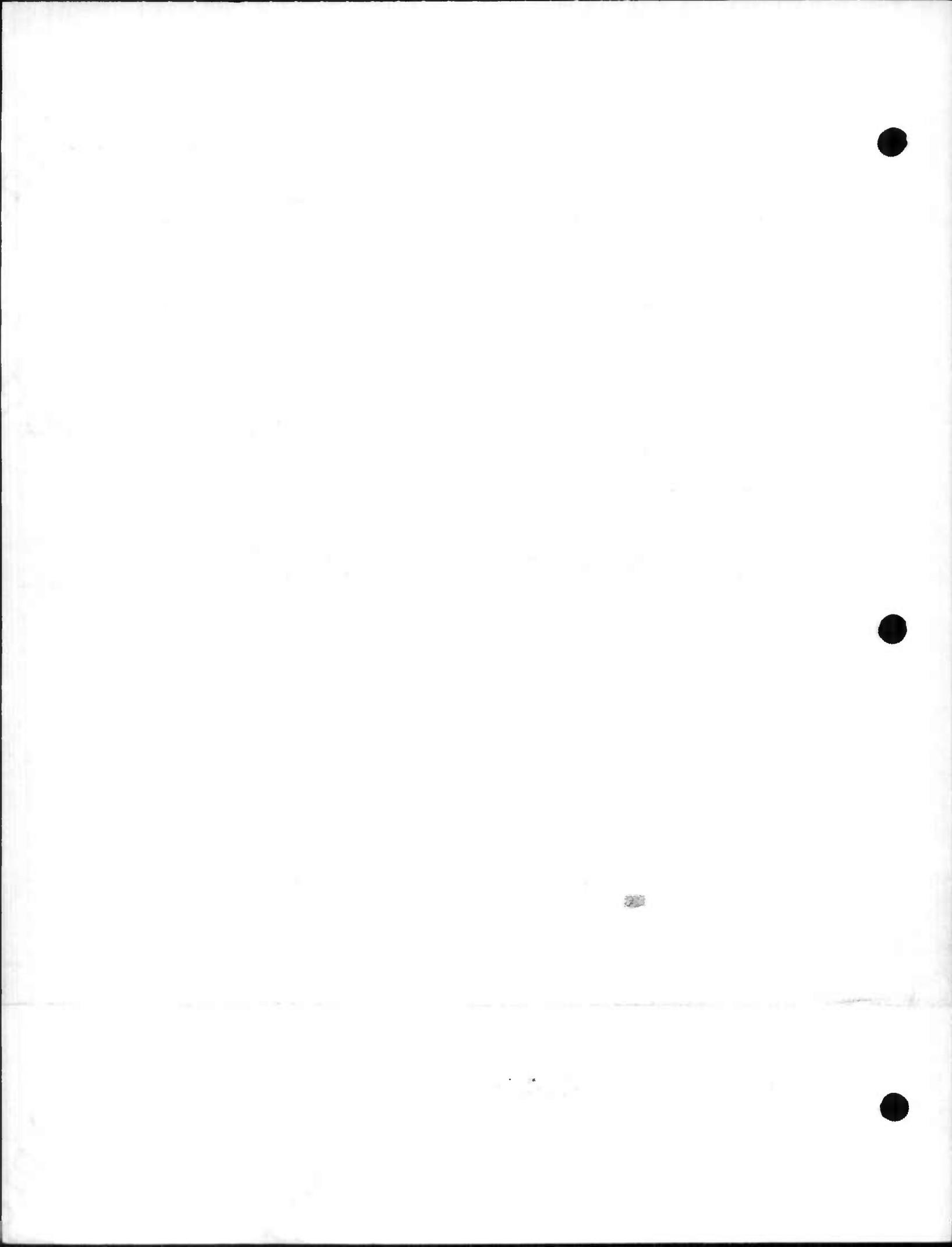
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR															
1. DECEDENT'S NAME (First, Middle, Last) Evelyn Rosina Bechtel												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 1:05 P M		
4. SOCIAL SECURITY NUMBER 214-72-5249			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 10, 1908			8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center												9b. CITY, TOWN OR LOCATION OF DEATH Towson			
RESIDENCE OF DECEDENT												9c. COUNTY OF DEATH Baltimore			
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 7004 Marietta Avenue												10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home							
17. FATHER'S NAME (First, Middle, Last) Warren B. Bruce								18. MOTHER'S NAME (First, Middle, Maiden Surname) Corinne Anderson							
19e. INFORMANT'S NAME (Type/Print) Mr. Karl A. Steinmetz					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7004 Marietta Avenue Baltimore, Md. 21234					20c. LOCATION — City or Town, State Baltimore, Maryland					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donor <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery				DATE 6/27/95	20c. LOCATION — City or Town, State Baltimore, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Mark T. Zavoya												22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc.			
												5305 Harford Road Baltimore, Md. 21214			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Respiratory failure <small>DUE TO (OR AS A CONSEQUENCE OF):</small> Staph aureus bronchopneumonia <small>DUE TO (OR AS A CONSEQUENCE OF):</small> Alimentary surgical wound dehiscence <small>DUE TO (OR AS A CONSEQUENCE OF):</small> Incarcerated inguinal hernia												5 wk.			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												5 wk.			
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure Congestive heart failure												5 wk.			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												6 wk.			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			28e. DATE OF INJURY (Month, Day, Year)			28d. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29d. SIGNATURE AND TITLE OF CERTIFIER STEPHEN R. SMITH, MD						29c. LICENSE NUMBER D-14957			29d. DATE SIGNED (Month, Day, Year) ► 6-25-95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN R. SMITH, MD, 8709 Harford Road, Baltimore, Md. 21234															
31. DATE FILED (Month, Day, Year) JUN 27 1995			32. REGISTRAR'S SIGNATURE Julie Shuler Karchell												



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

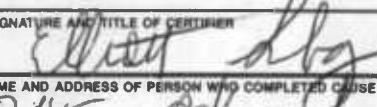
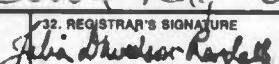
TO BE COMPLETED BY FUNERAL DIRECTOR

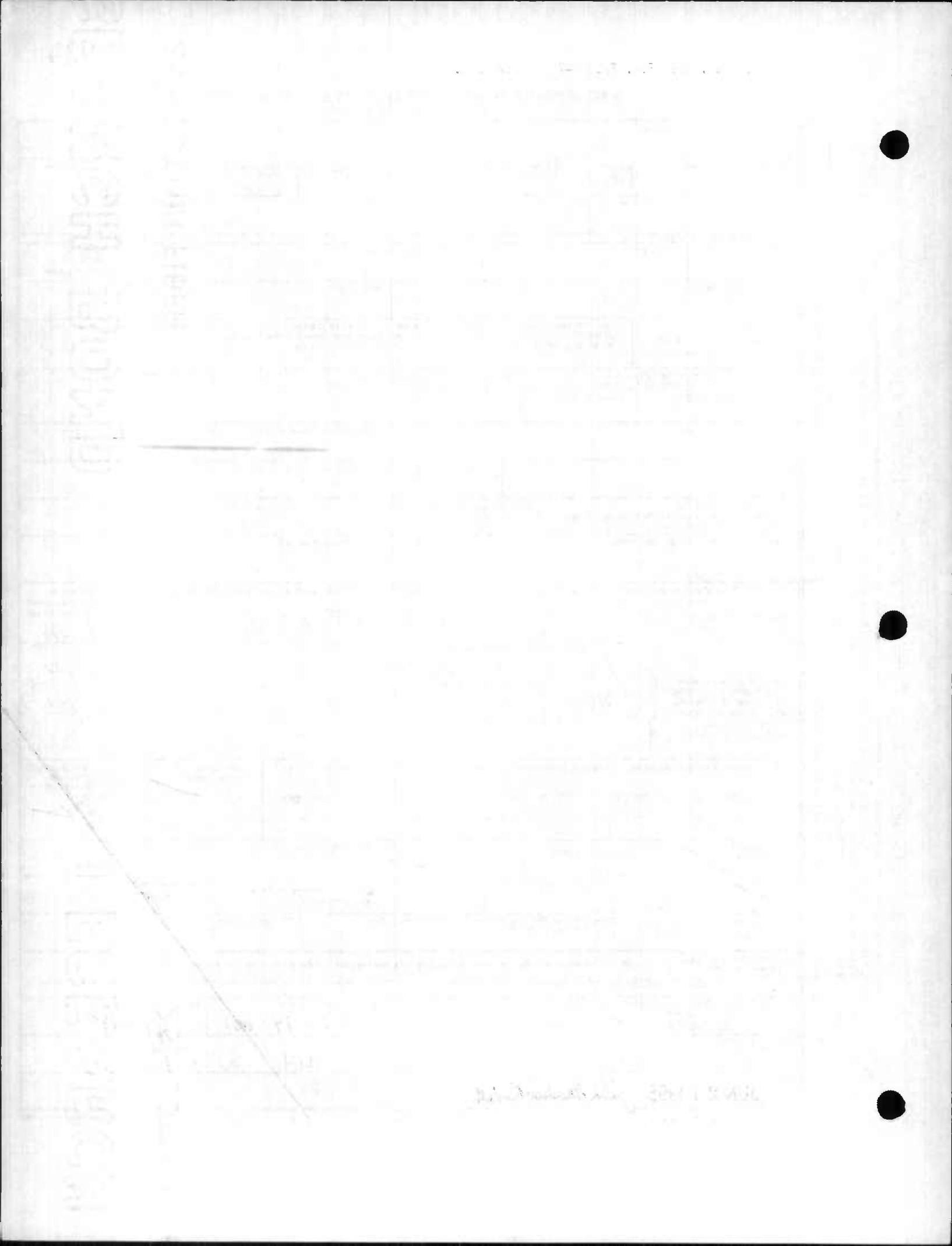
ITEM: 18. PER F.H. FILM G-724 6/27/95 t.t.

95 19334

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marcella NMN Bell				2. DATE OF DEATH MONTH DAY YEAR June 17 1995				3. TIME OF DEATH 3:00a.	
4. SOCIAL SECURITY NUMBER 224263822		5. SEX M	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 24, 1914		8. BIRTHPLACE (State or Foreign Country) Ohio	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Conv. Center				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie				9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie				10d. INSIDE CITY LIMITS? YES	
10a. STREET AND NUMBER 124 Main Ave.				10f. ZIP CODE 21061				10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS Never Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? NO		13. WAS DECEDENT OF NISPAHIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Edward Byrnes				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mabel + Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) MABEL ROGERS	
19a. INFORMANT'S NAME (Type/Print) Joan Mioduszewski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 208 Maple Ave. Glen Burnie, Md. 21061					
20a. METHOD OF DISPOSITION Burial				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery June 20, 95				DATE 20.95	20c. LOCATION — City or Town, State Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY McCullly Funeral Home 3204 Mountain Rd. Pasadena, Md. 21122					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Intestinal OBSTRUCTION</p> <p>DUE TO (OR AS A CONSEQUENCE OF): Alimentary Disease</p> <p>{ DUE TO (OR AS A CONSEQUENCE OF): Obstruction</p> <p>DUE TO (OR AS A CONSEQUENCE OF): Alimentary Disease</p> <p>Approximate Interval Between Onset and Death 1 week</p> <p>10 years 20 years</p>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient ER/Outpatient DOA OTHER: Nursing Home Residence Other (Specify)							
27. MANNER OF DEATH Natural Accident Suicide Homicide		28a. DATE OF INJURY (Month, Day, Year) 6/20/95	28b. TIME OF INJURY M 1	28c. INJURY AT WORK? NO	28d. DESCRIBE HOW INJURY OCCURRED				
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2845 Oakwood Rd., Glen Burnie, Md. 21061							
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN		29b. SIGNATURE AND TITLE OF CERTIFIER 							
29c. MEDICAL EXAMINER MEDICAL EXAMINER		29d. LICENSE NUMBER D 20094 wj							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John D. Walker		31. DATE FILED (Month, Day, Year) JUN 27 1995							
32. REGISTRAR'S SIGNATURE 									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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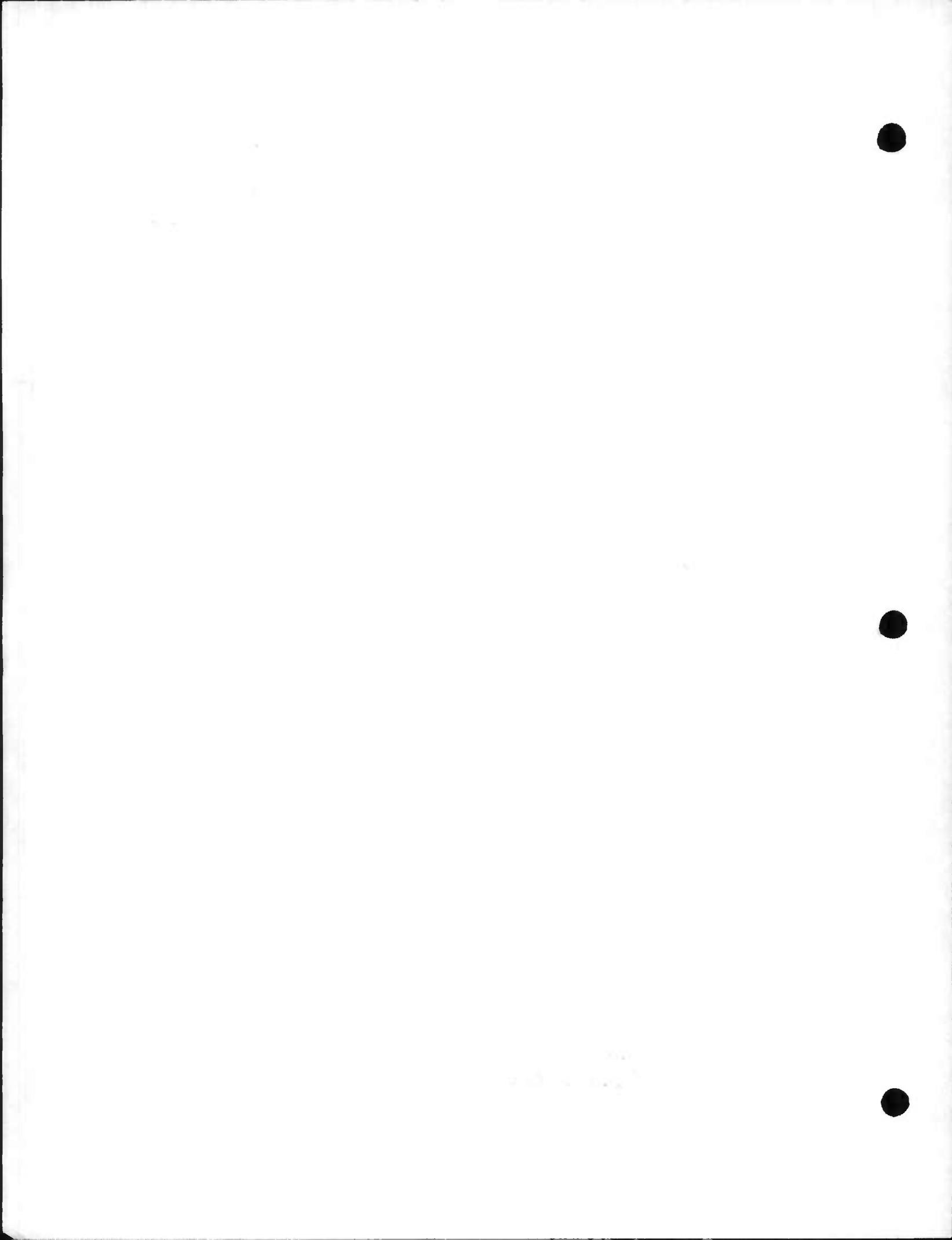
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - FOR STATE REGISTRAR										95 19335					
1. DECEASED'S NAME (First, Middle, Last)										2. DATE OF DEATH					
ROBERT B BUTLER										JUN. 21st 1995					
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		3. TIME OF DEATH					
220-22-1568		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		72 YRS.		MONTHS		DAYS		YEAR					
8a. FACILITY NAME (If not institution, give street and number)										7. DATE OF BIRTH (Month, Day, Year)					
NORTH ARUNDEL HOSPITAL ASSOCIATION										Dec. 26, 1922					
9b. CITY, TOWN OR LOCATION OF DEATH										8. BIRTHPLACE (State or Foreign Country)					
GLEN BURNIE										Maryland					
9c. COUNTY OF DEATH										A.A. COUNTY					
RESIDENCE OF DECEASED															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?					
MD		Anne Arundel		Millersville						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER										10f. ZIP CODE					
899 Cecil Avenue										21108					
10g. CITIZEN OF WHAT COUNTRY?										USA					
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:					
<input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced										14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 5		Attendant								Hospital					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Unknown										Loretta Green					
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
Frank Butler		813 Annapolis Road, Gambrills, MD 21054													
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)								20c. LOCATION — City or Town, State					
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		Metro Crematory								DATE 6/22 Baltimore, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY													
<i>Bethel J. Hill</i>		Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401													
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										<i>Pulmonary fibrosis</i> , years					
a. DUE TO (OR AS A CONSEQUENCE OF):															
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.															
<i>Auto renal failure, vocal folds</i>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)								24a. WAS AN AUTOPSY PERFORMED?					
<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED							
1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		M		1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER										29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		<i>HSLU HUNG</i>										D 25000		<i>June 22, 1995</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
PO-HSLU HUNG, M.D./1916 CRAIN HIGHWAY, SW #8/GLEN BURNIE, MD 21061															
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE													
JUN 27 1995		<i>J. Arundel Butler</i>													



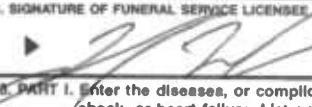
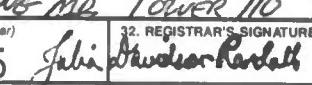
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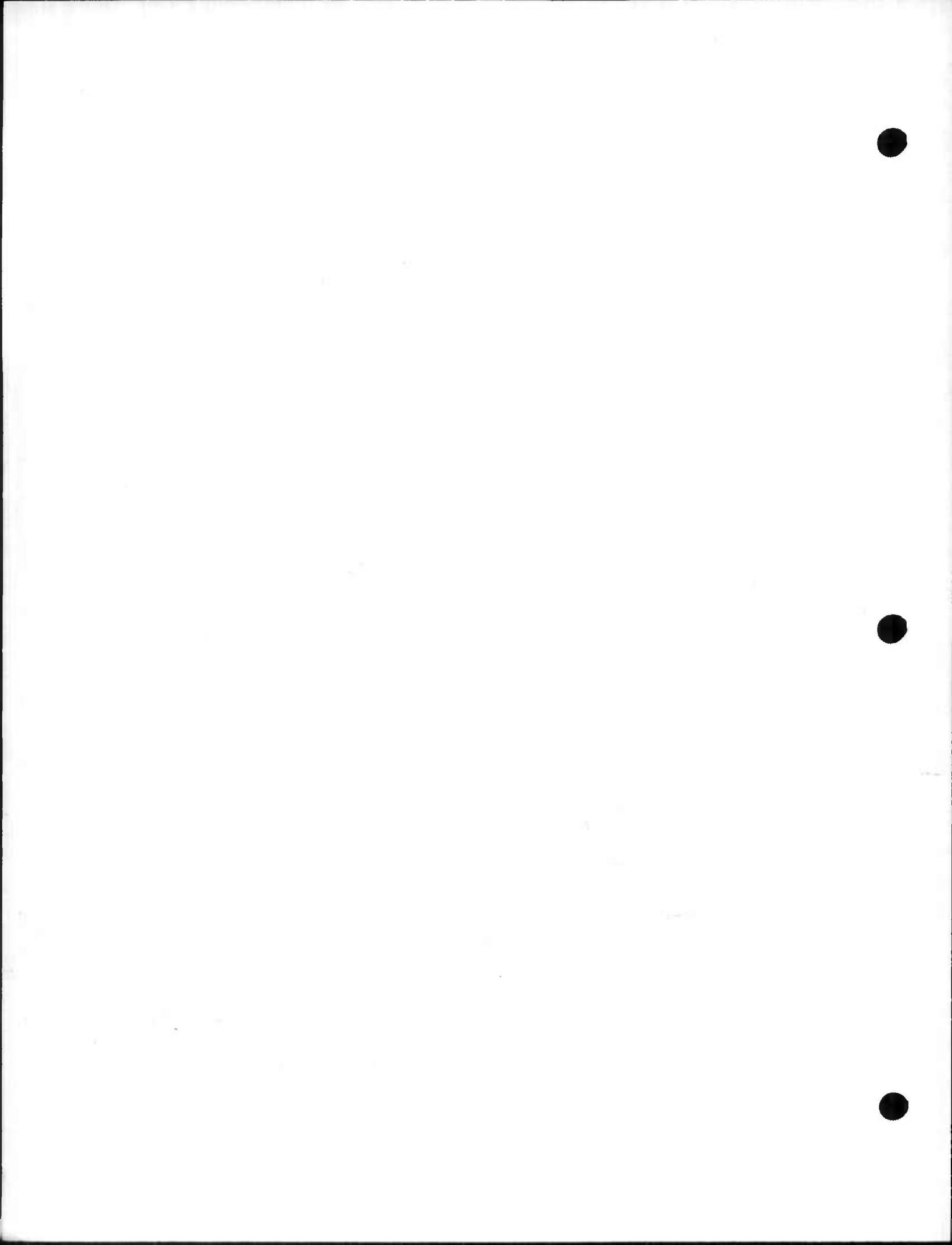
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.								
1. DECEASED'S NAME (First, Middle, Last) DARLENE JOYCE BORMEL							2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH P.M.								
4. SOCIAL SECURITY NUMBER 220-52-3092		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 5/4/49		8. BIRTHPLACE (State or Foreign Country) Maryland							
8a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL							9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH N/A								
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Cub Hill				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER 8932 Satyr Hill Road							10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA								
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th Grade		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home												
17. FATHER'S NAME (First, Middle, Last) Alfred Klaburner							18. MOTHER'S NAME (First, Middle, Maiden Surname) Lenora Thistel										
19a. INFORMANT'S NAME (Type/Print) Allan Bormel							19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8932 Satyr Hill Road Baltimore, MD 21234										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)							20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		DATE 6/26/95	20c. LOCATION — City or Town, State Baltimore, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 							22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GASTROINTESTINAL HEMORRHAGE <small>DUE TO (OR AS A CONSEQUENCE OF):</small> b. GASTROESOPHAGEAL VARICES <small>DUE TO (OR AS A CONSEQUENCE OF):</small> c. CIRRHOSIS, HEPATIC <small>DUE TO (OR AS A CONSEQUENCE OF):</small> d.																	
Approximate Interval Between Onset and Death 18 HOURS 1 YEAR 10 YEARS																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <small>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</small>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. MANNER OF DEATH <table border="1"> <tr> <td><input checked="" type="checkbox"/> Natural</td> <td><input type="checkbox"/> Pending investigation</td> </tr> <tr> <td><input type="checkbox"/> Accident</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Suicide</td> <td><input type="checkbox"/> Could not be determined</td> </tr> <tr> <td><input type="checkbox"/> Homicide</td> <td></td> </tr> </table>					<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide	
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																
<input type="checkbox"/> Accident																	
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																
<input type="checkbox"/> Homicide																	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED											
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER P08016		29d. DATE SIGNED (Month, Day, Year) JUNE 22, 1995													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID F. KONG MD		31. DATE FILED (Month, Day, Year) JUN 27 1995															
32. REGISTRAR'S SIGNATURE 																	

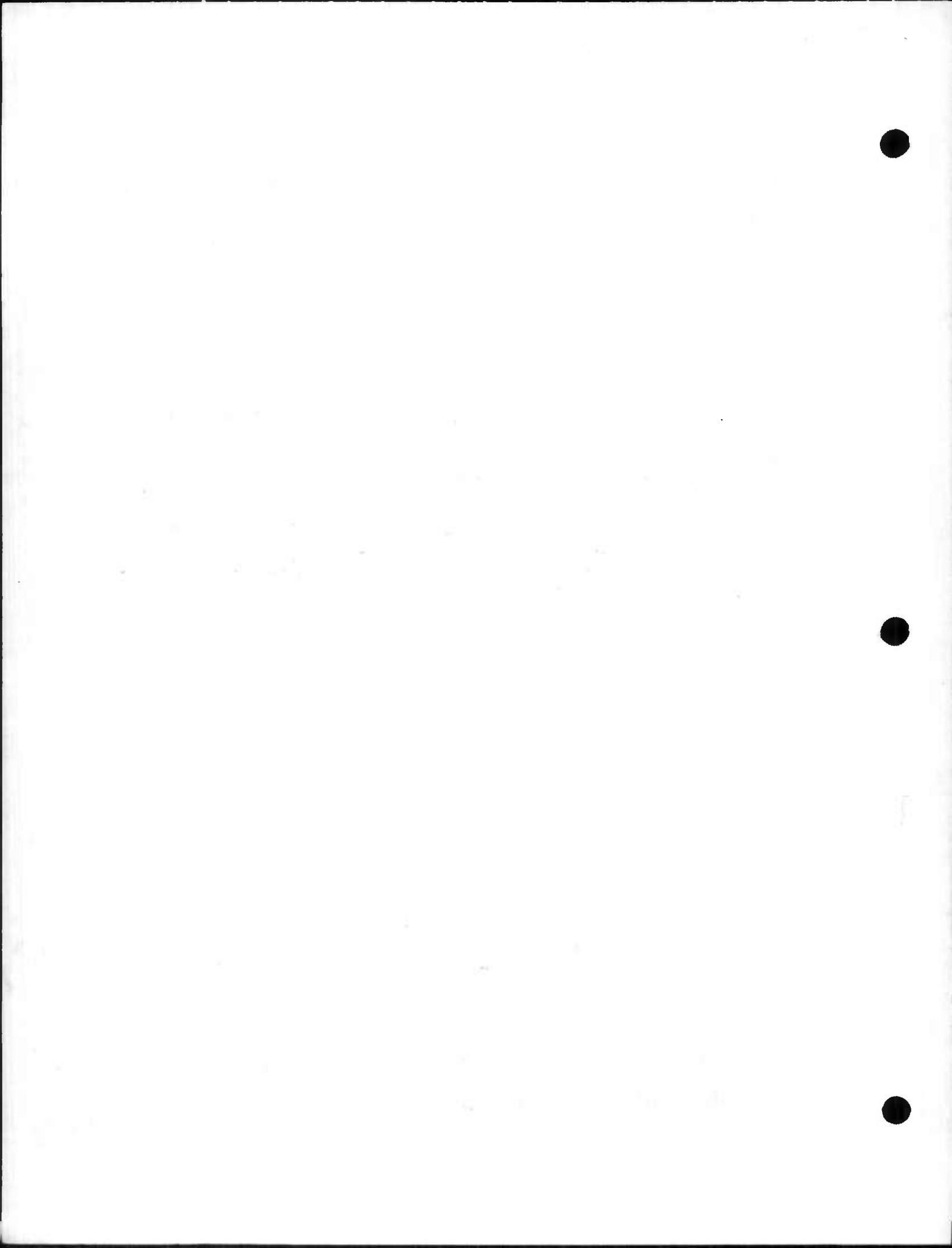


ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/6/95 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LARRY Lewis BINGHAM						2. DATE OF DEATH MONTH JUNE DAY 22, 1995 YEAR	3. TIME OF DEATH 17:02 P M	
4. SOCIAL SECURITY NUMBER 213-82-0901		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 31 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) DEC. 16, 1963		8. BIRTHPLACE (State or Foreign Country) MARYLAND
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY HOSPITAL ER				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH N/A	
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1103 W. HAMBURG ST.				10f. ZIP CODE 21230			10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If YES, GIVE WAR OR DATES X			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: WHITE		14. RACE — American Indian, Black, White, etc. Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) MECHANIC			16b. KIND OF BUSINESS/INDUSTRY AUTOMOBILE			
17. FATHER'S NAME (First, Middle, Last) RALPH BINGHAM				18. MOTHER'S NAME (First, Middle, Maiden Surname) LINDA KASOFF				
19a. INFORMANT'S NAME (Type/Print) MR. RALPH BINGHAM				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1103 W. HAMBURG ST. BALTIMORE, MD 21230				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) HEBREW YOUNG MEN		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SOL LEVINSON & BROS., INC.			DATE 6-25-95	20c. LOCATION — City or Town, State BALTIMORE, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC AND ALCOHOL INTOXICATION								
Approximate interval Between Onset and Death								
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that Initiated events resulting in death) LAST								
b. DUE TO (OR AS A CONSEQUENCE OF):								
c. DUE TO (OR AS A CONSEQUENCE OF):								
d. DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) UNKNOWN				28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 6-22-95		28b. TIME OF INJURY UNKNOWN	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1103 W. HAMBURG ST. BALTIMORE, MD		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAY ALAN LEWIS, MD 111 Penn Street, Baltimore, Maryland 21201								
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 						



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

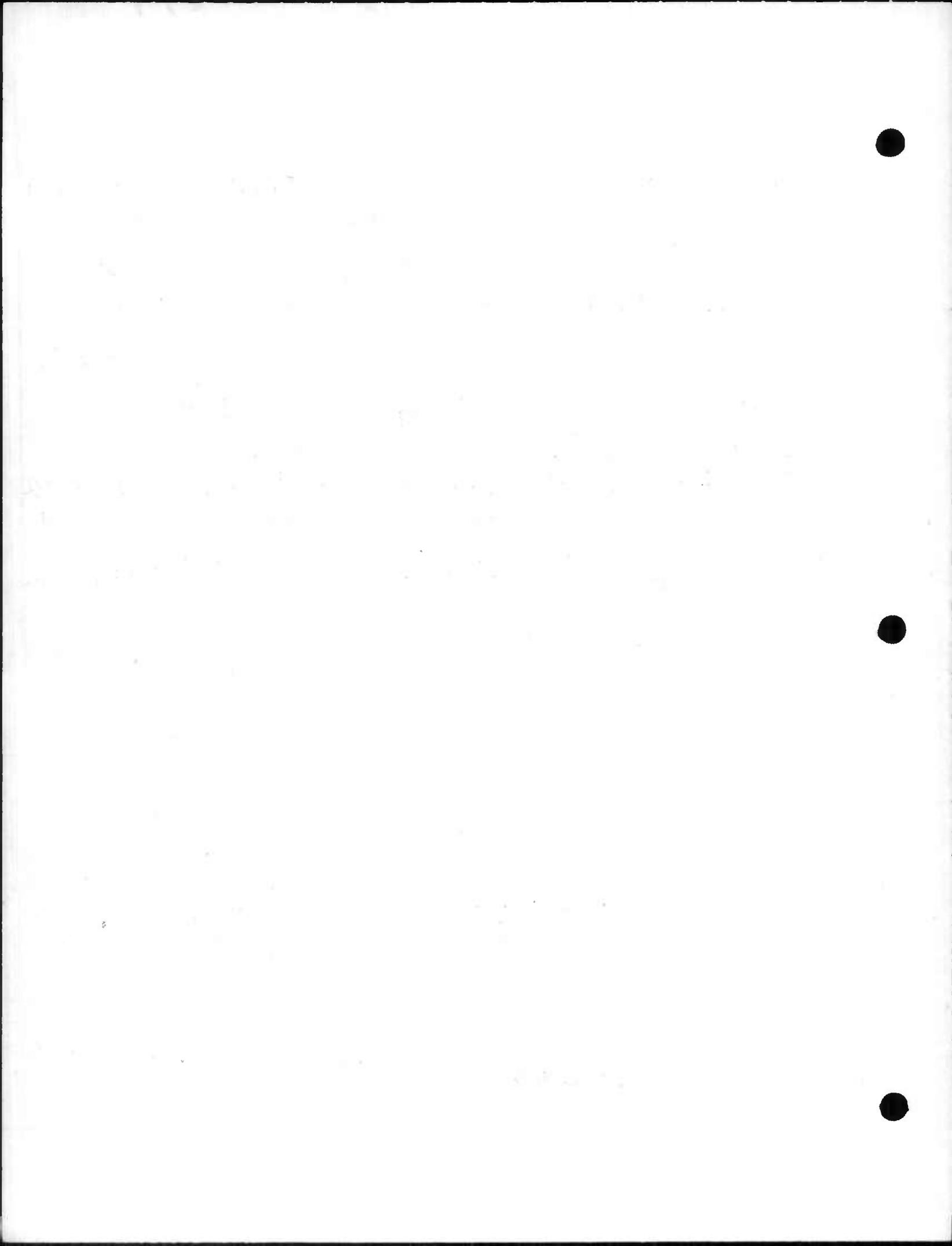
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR												
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
JAMES E. COURTS										JUNE 18, 1995	0750 A M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
212-56-4099		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	44 YRS.	MONTHS	DAYS	HOURS	MIN.	July 17, 1950		Maryland		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH								9c. COUNTY OF DEATH		
4501 PIMLICO ROAD		BALTIMORE CITY								N/A		
RESIDENCE OF DECEDENT												
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?						
Maryland		N/A		Baltimore		<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?		
742 Glenwood Ave.		21212								USA		
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12)		O unemployed								N/A		
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)										
Eddie Courts		Lula Noe										
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Ernestine Quick		742 Glenwood Ave, Balto, Md. 21212										
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place)								20c. LOCATION — City or Town, State		
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) MT. ZION										6/29/95 Lansdowne, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY										
► Joseph L. Russ		Joseph L. Russ Funeral Home 2222 W. North Ave, Balto, Md. 21216										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. Narcotic Intoxication DUE TO (OR AS A CONSEQUENCE OF):												
b. [Blank] DUE TO (OR AS A CONSEQUENCE OF):												
c. [Blank] DUE TO (OR AS A CONSEQUENCE OF):												
d. [Blank]												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED?	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
										<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		28. PLACE OF DEATH (Check only one)										
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year) found: 6/18/95		28b. TIME OF INJURY 7:40a M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED Unknown				
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide												
29e. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) house								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 4501 Pimlico rd., Baltimore, MD		
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD		29c. LICENSE NUMBER O.C.M.E								29d. DATE SIGNED (Month, Day, Year) JUNE 18, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
DONALD G. WRIGHT MD 111 Penn Street, Baltimore, Maryland 21201												
31. DATE FILED (Month, Day, Year) JUN 27 1995		31. DATE FILED (Month, Day, Year) JUN 27 1995										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

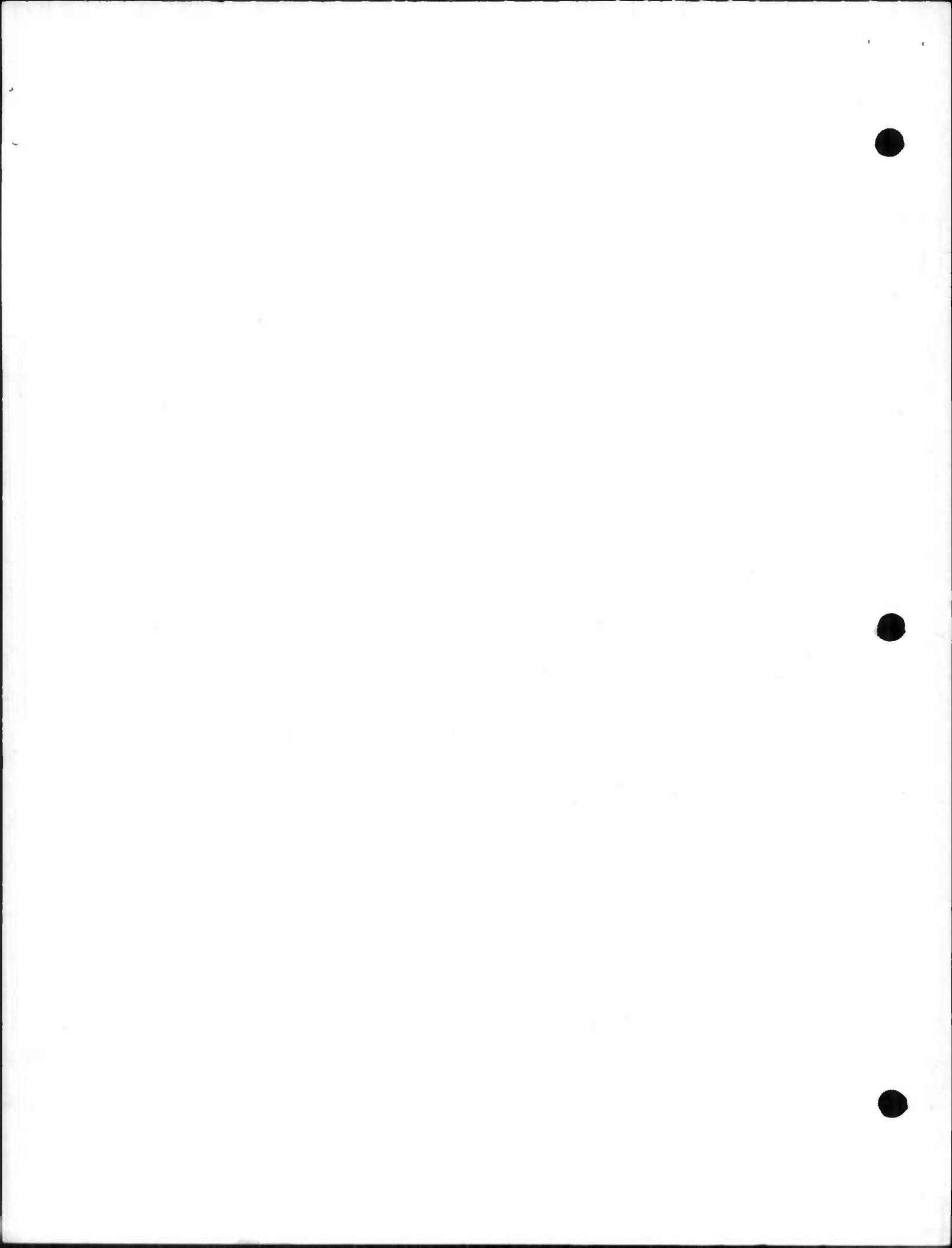
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19339

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH			
Thomas Harrison Campbell Sr.						June 22, 1995 4:30pm M				
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
219-14-2180		<input checked="" type="checkbox"/> M <input type="checkbox"/> F	69 YRS.	MONTHS	DAYS	March 26, 1926		Maryland		
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH				
7026 Conley Street			Baltimore			Baltimore				
RESIDENCE OF DECEDENT										
10e. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS?					
Md.	Baltimore	Baltimore			<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER				10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?					
7026 Conley Street				21224	USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced										
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 8th		College (1-4 or 5+)			Warehouseman			n/a		
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)						
William K. Campbell				Anna L. Michaels						
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Thomas H. Campbell Jr.				700 Pine Branch Place Baltimore Md. 21221						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Cemetery			DATE	20c. LOCATION — City or Town, State				
					6/27/95	Owings Mills MD.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY						
► R. Terry Connally				Connally Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221						
23. PART I. Enter the diseases, complications that caused the death! Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden death, presumed acute myocardial infarct DUE TO (OR AS A CONSEQUENCE OF):										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
b. Atherosclerosis DUE TO (OR AS A CONSEQUENCE OF): c. Atrial fibrillation DUE TO (OR AS A CONSEQUENCE OF): d. previous cerebrovascular accident										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Cerebral Hypertension										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/>										
25. HAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)								
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. INJURY AT WORK?	28d. DESCRIBE HOW INJURY OCCURED				
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				M	1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29e. CERTIFIER (Check only one)		29f. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29g. SIGNATURE AND TITLE OF CERTIFIER Gary B. Ruppert MD		29c. LICENSE NUMBER D18446			29d. DATE SIGNED (Month, Day, Year) ► 23 June 95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)										
GARY B. RUPPERT 301 St. Paul Pl. #411 Balt. 21202										
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE John Shuler, R.R.C.								
JUN 27 1995										

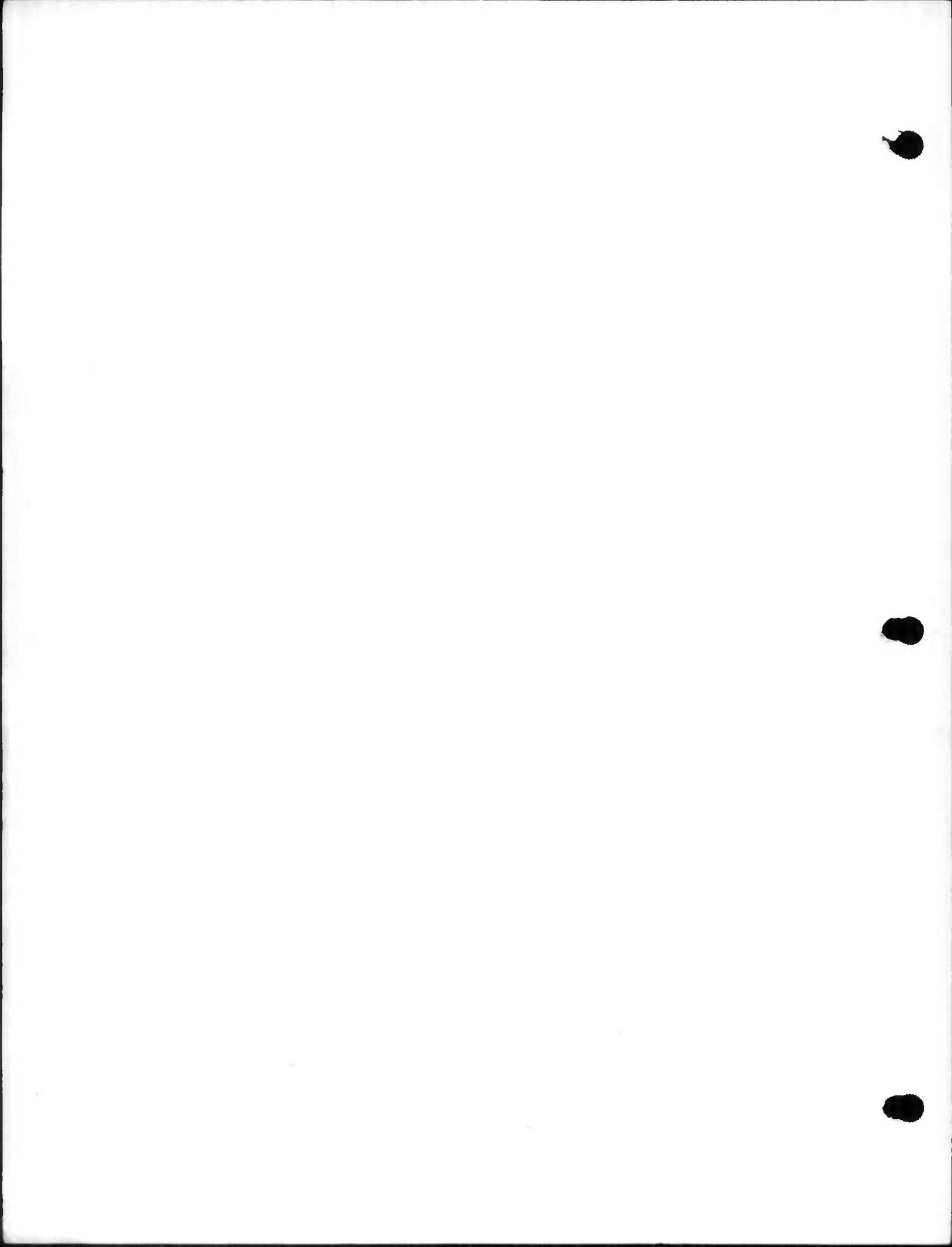


DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Carol Jean Cochrane						2. DATE OF DEATH MONTH DAY YEAR June 23, 1995		3. TIME OF DEATH A.M. 0454		
4. SOCIAL SECURITY NUMBER 587-98-9247		5. SEX M	6. AGE (In yrs. last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 24, 1952		8. BIRTHPLACE (State or Foreign Country) Florida		
9a. FACILITY NAME (If not institution, give street and number) Kimbrough Army Comm Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Ft. Meade		9c. COUNTY OF DEATH Anne Arundel		
10a. RESIDENCE OF DECEDENT STATE: MD COUNTY: Anne Arundel						10c. CITY, TOWN OR LOCATION Ft. Meade		10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
10e. STREET AND NUMBER 4237 Coyle Court						10f. ZIP CODE 20755		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> Specify: White			14. RACE — American Indian, Black, White, etc. White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Manager			16b. KIND OF BUSINESS/INDUSTRY Food Industry				
17. FATHER'S NAME (First, Middle, Last) Harold West						18. MOTHER'S NAME (First, Middle, Maiden Surname) Bennie Jaco				
19a. INFORMANT'S NAME (Type/Print) Patrick F. Cochrane				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4237 Doyle Court, Ft. Meade, MD 20755						
20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/>			20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Arlington National Cem.			20c. LOCATION — City or Town, State Arlington, VA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas J. Hardesty				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiopulmonary arrest <small>DUE TO (OR AS A CONSEQUENCE OF)</small> b. Small cell carcinoma of cervix <small>DUE TO (OR AS A CONSEQUENCE OF)</small> c. <small>DUE TO (OR AS A CONSEQUENCE OF)</small> d. 									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <hr/> <hr/> <hr/>									24a. WAS AN AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input checked="" type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <input type="checkbox"/>								
27. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	28d. DESCRIBE HOW INJURY OCCURRED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) MARK REED <input checked="" type="checkbox"/>		29b. SIGNATURE AND TITLE OF CERTIFIER MARK REED								
29c. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARK REED Walter Reed Army Medical Center, Washington DC		29d. LICENSE NUMBER TN M000000 20450		29e. DATE SIGNED (Month, Day, Year) 6/26/95						
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Jabi Dawson-Roddell								



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

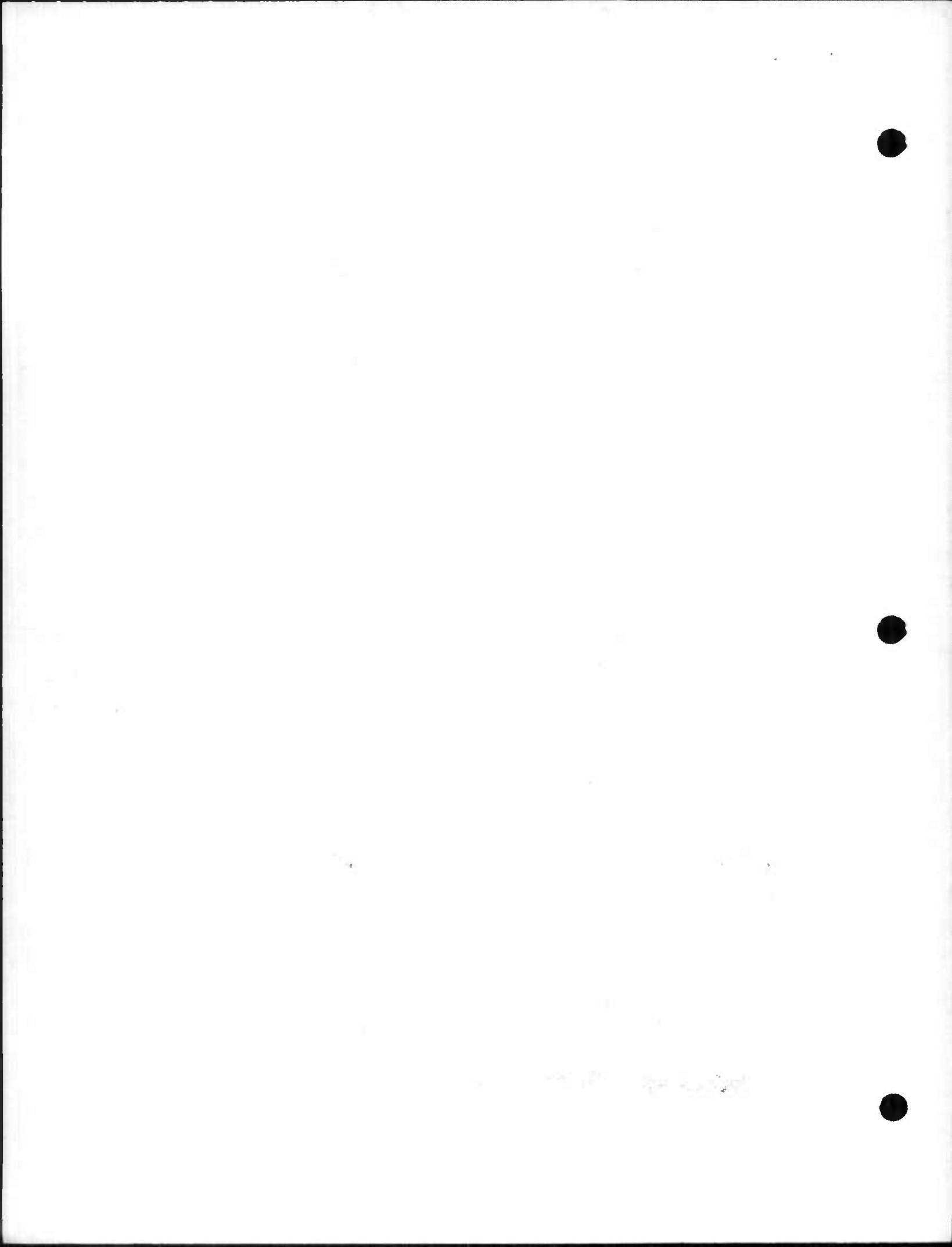
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 95 19341	
1 - STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH	3. TIME OF DEATH
MARIA OLHA CHOMA												MONTH JUNE DAY 26, YEAR 1995	12:15 A.M.
4. SOCIAL SECURITY NUMBER 220-66-5557			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 77 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH Month, Day, Year June 8, 1918	6. BIRTHPLACE (State or Foreign Country) Ukraine	
8a. FACILITY NAME (If not institution, give street and number) 1420 Elmtree Street,			8b. CITY, TOWN OR LOCATION OF DEATH Baltimore (Curtis Bay)			8c. COUNTY OF DEATH NA							
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore (Curtis Bay)						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 1420 Elmtree Street				10f. ZIP CODE 21226			10g. CITIZEN OF WHAT COUNTRY? Ukraine						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Saturday Teacher			16b. KIND OF BUSINESS/INDUSTRY Ukrainian School								
17. FATHER'S NAME (First, Middle, Last) Anton Diwnycz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Olha Zavadska									
19e. INFORMANT'S NAME (Type/Print) Mr. Michajlo Choma				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1420 Elmtree St., Baltimore, Md. 21226									
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) St. Michael's Ukrainian Cem. 6/30/95			20c. LOCATION — City or Town, State Baltimore, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>K.E.</i>				22. NAME AND ADDRESS OF FACILITY McCullly Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): <i>Hyperthyroidism</i>												6/95	
b. Hypertension DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes</i>												83	
c. Diabetes DUE TO (OR AS A CONSEQUENCE OF): <i>Myocardial Infarction</i>												84	
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Insufficiency</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			OTHER:							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28e. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
			26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29f. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. George H. Hebard</i>						29c. LICENSE NUMBER D31944			29d. DATE SIGNED (Month, Day, Year) ► 6-26-95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. George H. Hebard, M.D., 4710 Pennington Ave., Balto., Md. 21226													
31. DATE FILED JUN 27 1995			32. REGISTRAR'S SIGNATURE <i>John A. Schaefer</i>										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

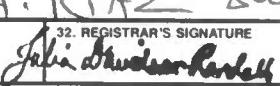
TO BE COMPLETED BY FUNERAL DIRECTOR

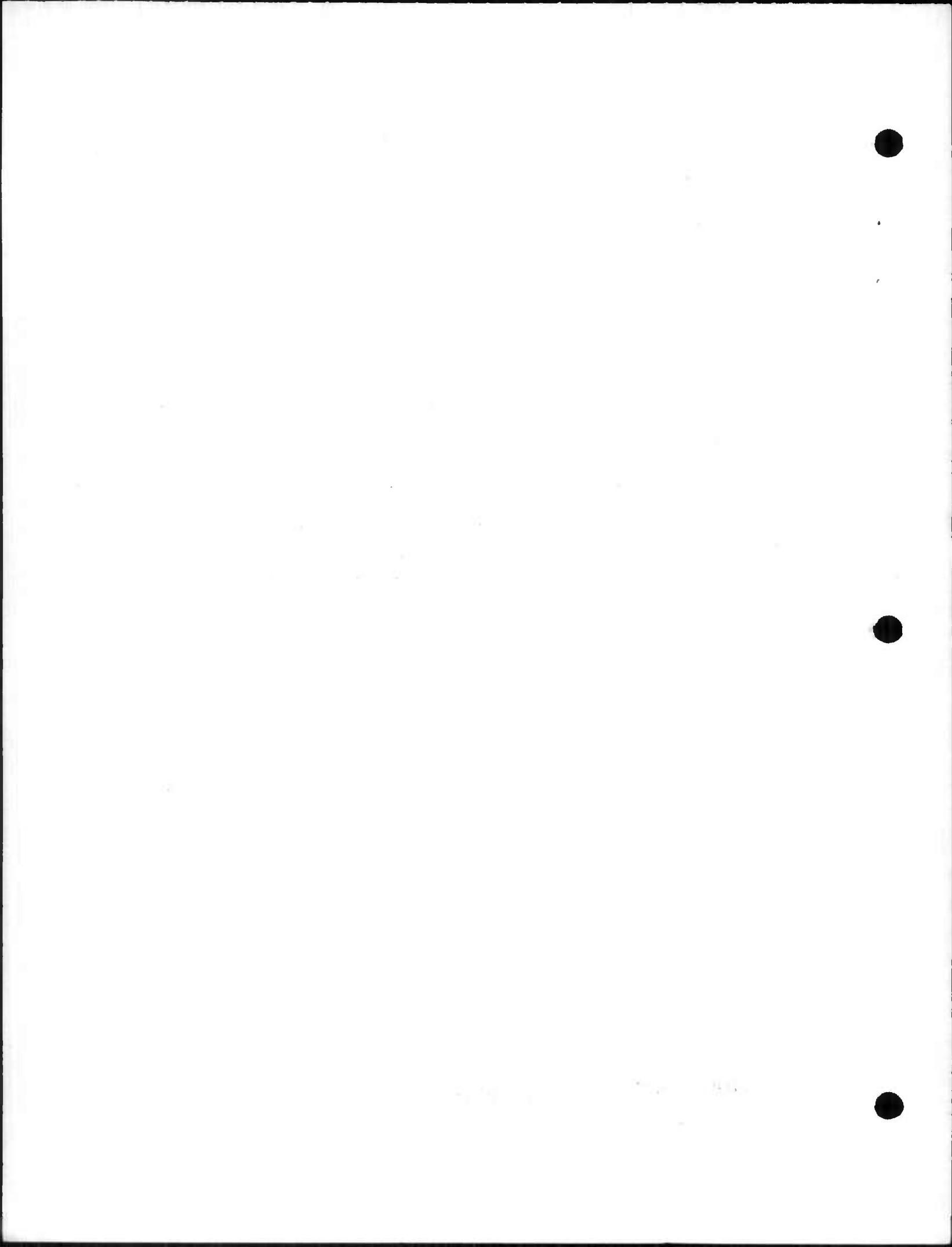
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19342

1. DECEDENT'S NAME (First, Middle, Last)		VIOLA BLANCHE CRULL				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 8:30 A M
4. SOCIAL SECURITY NUMBER 212-48-9087		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Jan. 8, 1906	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Meridian Nursing Center-Hammonds Ln.		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore (Baltimore Highlands)			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 2925 Florida Avenue					10f. ZIP CODE 21227	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Housewife & Mother		
17. FATHER'S NAME (First, Middle, Last) William Prinz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Eyring			
19a. INFORMANT'S NAME (Type/Print) Mrs. Irene Roberta Chaney				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2925 Florida Ave., Baltimore, Maryland 21227			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory, or other place) Loudon Park Cemetery			DATE 6/24/95	20c. LOCATION — City or Town, State Baltimore, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY McCullly Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>b. <i>Congestive Heart Failure</i></p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. _____</p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p>							
Approximate Interval Between Onset and Death 1 week							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER D40491		29d. DATE SIGNED (Month, Day, Year) ► 6-21-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SYED M.A. RIAZ 800 N. Hammonds Ferry Road Linthicum 21090							
31. DATE (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

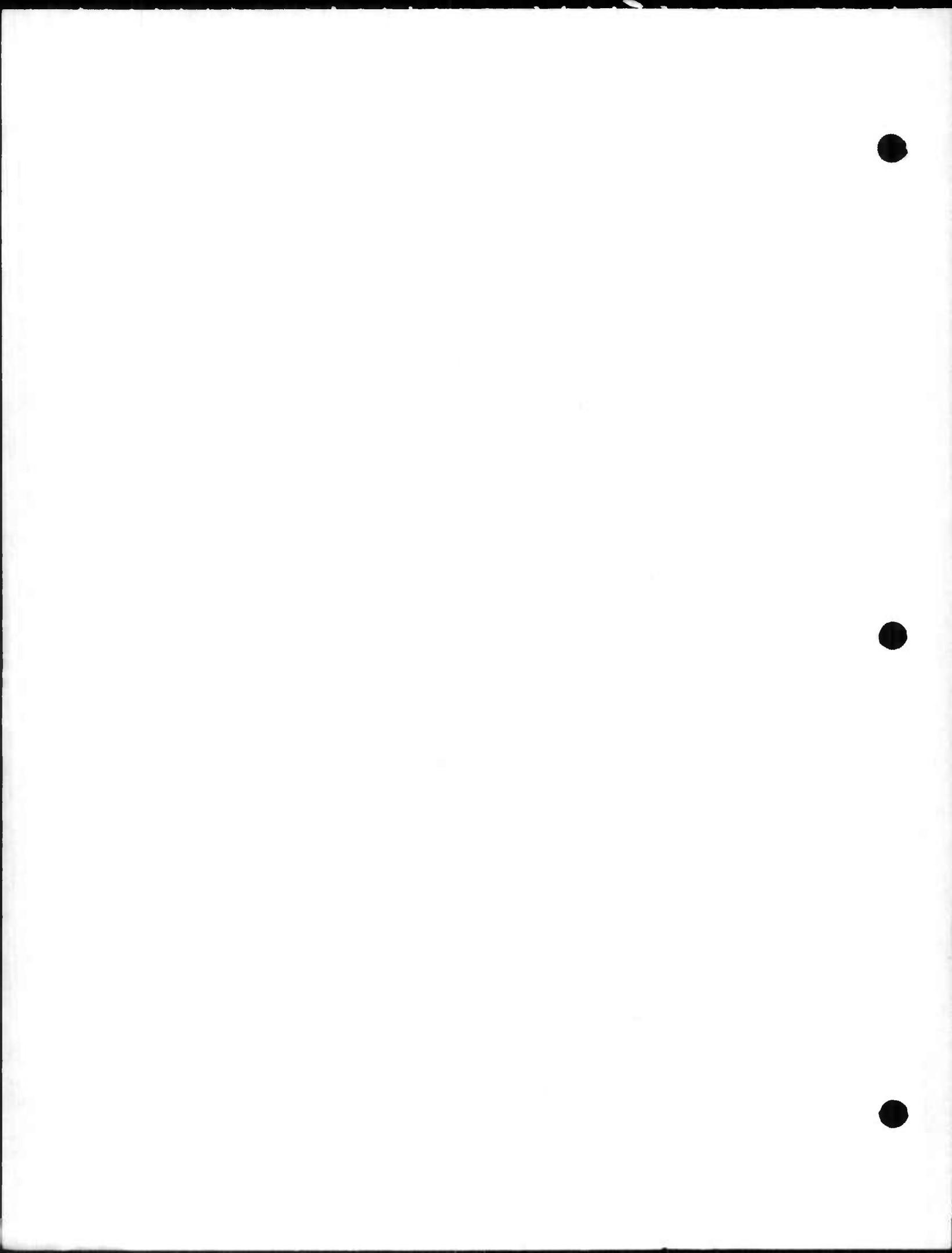
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Charles H. Crowder											June 24 1995 11 10 AM	M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)				
240-36-1741		1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> F	65			1/26/30		N. CAROLINA				
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH			9c. COUNTY OF DEATH							
Northwest Hospital Center		Randallstown, MD			Baltimore							
RESIDENCE OF DECEDENT												
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?				
Maryland	n/a	Baltimore						1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?					
3114 FAIRVIEW AVENUE				21207			USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)			14. RACE — American Indian, Black, White, etc. Specify:				
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		10/6/53 10/5/55			1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+)			Diesel Engineer			Bus Company				
12th		3+										
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)								
Samuel Crowder				Cassie Simon								
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Ruth Crowder				3114 Fairview Avenue Baltimore, MD. 21207								
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			20c. DATE			20c. LOCATION — City or Town, State				
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Garrison Forest Vet. Cem.			6/29			Owings Mills, MD.				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY								
Leroy O. Dyett				LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Approximate Interval Between Onset and Death												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. Congestive Heart Failure												
DUE TO (OR AS A CONSEQUENCE OF):												
b. Amyloid Heart Disease												
DUE TO (OR AS A CONSEQUENCE OF):												
c. DUE TO (OR AS A CONSEQUENCE OF):												
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)										
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA			OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED				
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER										
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER										
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29d. DATE SIGNED (Month, Day, Year)										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
Judie Minkov 750 Main St Reisterstown MD 21132												
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE										
JUN 27 1995		Julie Anderson-Krueger										



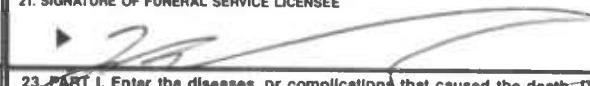
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

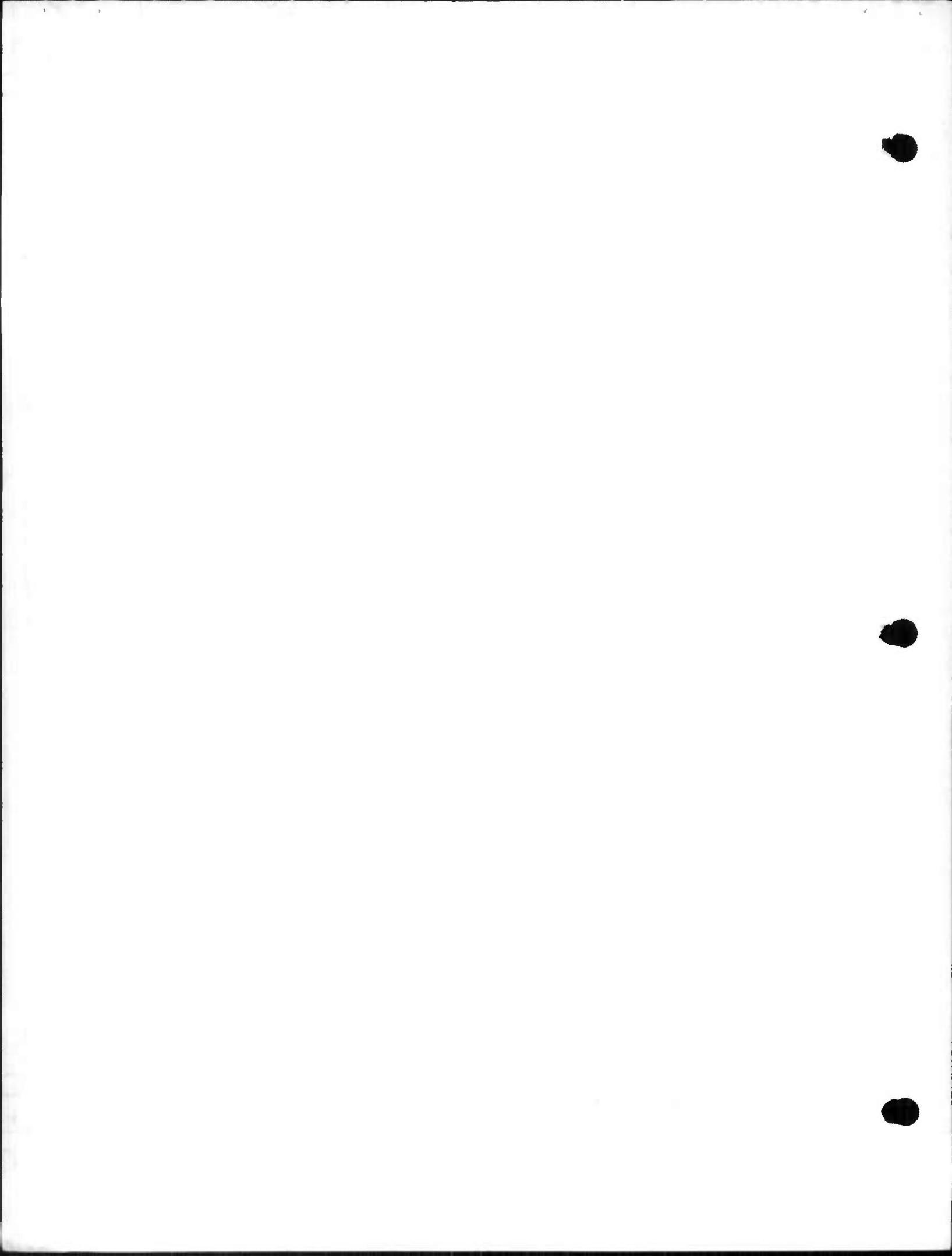
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH 6 DAY 22 YEAR 11:35 PM								3. TIME OF DEATH					
1. DECEDENT'S NAME (First, Middle, Last) Hercelice LILJEBLAD Chrest										7. DATE OF BIRTH (Month, Day, Year) 12/12/19	8. BIRTHPLACE (State or Foreign Country) Maryland				
4. SOCIAL SECURITY NUMBER 212-09-8238		5. SEX M 2 F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9. FACILITY NAME (If not Institution, give street and number) Dulaney Towson Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH Towson	9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDED										10d. INSIDE CITY LIMITS? 1 YES 2 NO					
10e. STATE Maryland	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore City								10d. CITIZEN OF WHAT COUNTRY? USA					
10e. STREET AND NUMBER 6401 Loch Raven Blvd. Kirkwood House					10f. ZIP CODE 21239					10g. RACE — American Indian, Black, White, etc. Specify: WHITE					
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify:			14. RACE — American Indian, Black, White, etc. Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Secretary										
17. FATHER'S NAME (First, Middle, Last) James H. Smedley					18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary R. Figgins										
19a. INFORMANT'S NAME (Type/Print) Charles M. Smedley					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1832 Cromwood Road Baltimore, MD 21234										
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc.			DATE 6/24/95		20c. LOCATION — City or Town, State Catonsville, MD								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death					
a. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): coronary artery disease										years					
b. DUE TO (OR AS A CONSEQUENCE OF): Severe osteoporosis										years					
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Severe osteoporosis										24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO					
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: Nursing Home 5 Residence 8 Other (Specify)													
27. MANNER OF DEATH 1 Natural 5 Pending investigation 2 Accident 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 YES 2 NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Marie A Dobyns MD		29c. LICENSE NUMBER D29923		29d. DATE SIGNED (Month, Day, Year) 6/23/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARIE A DOBYNS 301 St Paul Place, Balt. Md. 21202															
31. DATE FILED (Month, Day, Year) JUN 27 1995												32. REGISTRAR'S SIGNATURE 			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

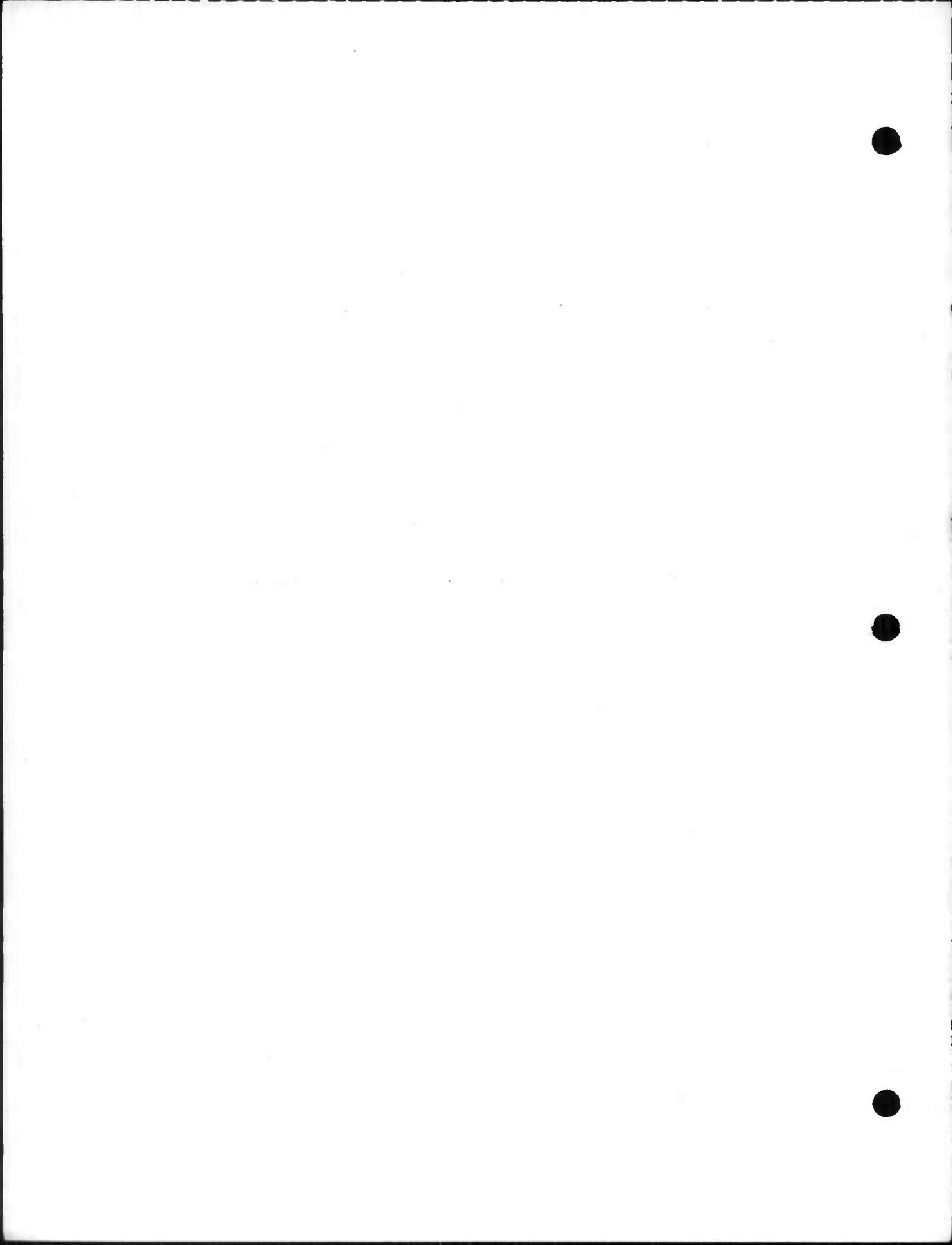
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

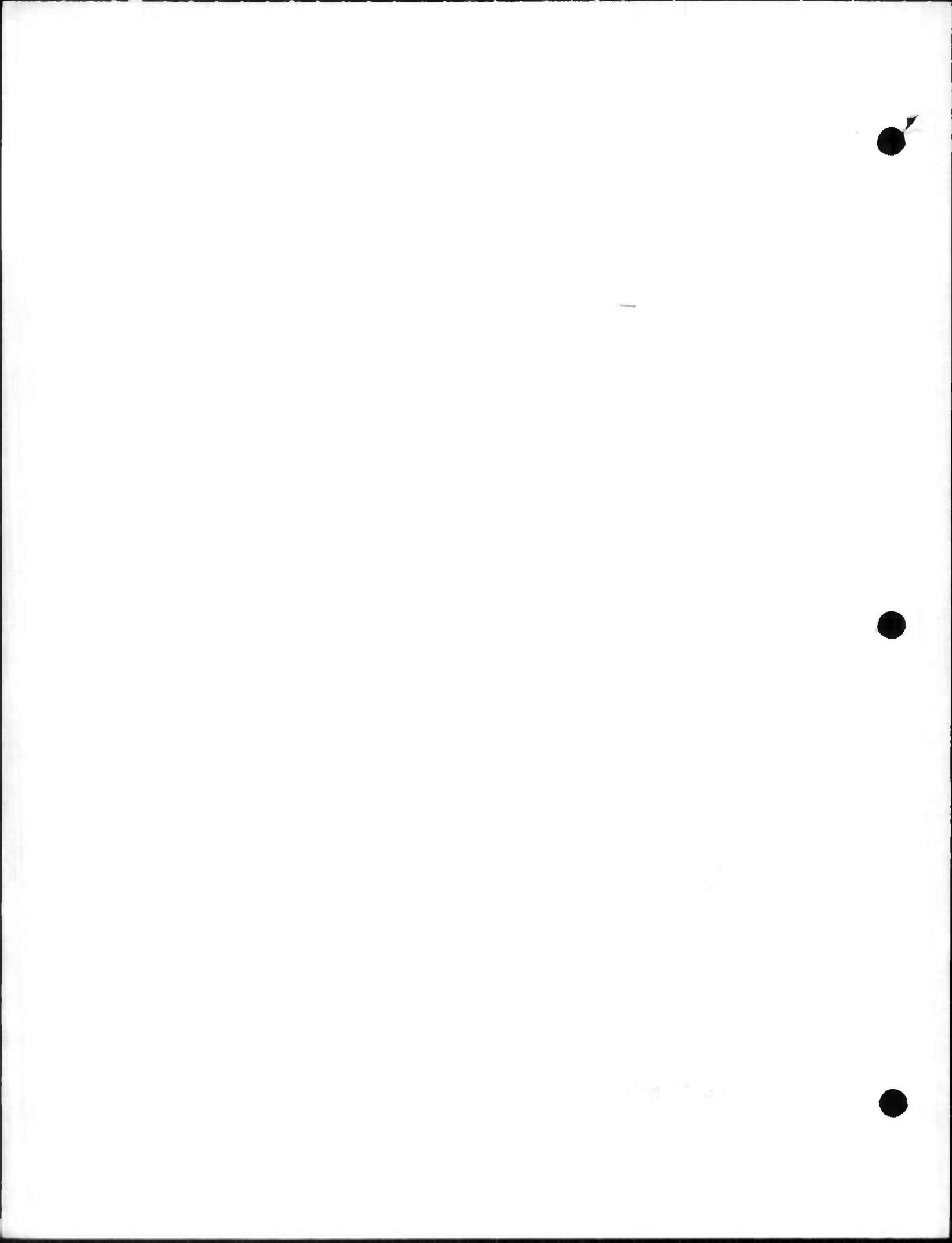
TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)		Gerald A. Daniels						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 1995 2:15 A.M.				
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)				
212-60-4394		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	43 YRS.	MONTHS	DAYS	HOURS	MIN.	06-01-52		MD.				
9a. FACILITY NAME (If not institution, give street and number)		LIBERTY MEDICAL CENTER						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH				
								BALTIMORE		N/A				
RESIDENCE OF DECEASED														
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?					
MD.	N/A		BALTIMORE						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?						
1011 WHITELOCK STREET		21217						USA						
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK						
1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced														
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY										
Elementary/Secondary (0-12) 12th		College (1-4 or S+)		LABORER				UNK						
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)								
ROBERT N. DANIELS						MARY ELIZABETH DANIELS								
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
MARY E. DANIELS		1011 WHITELOCK STREET BALTO. MD. 21217												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State								
		ARBUTUS CEMETERY 07-01-95				BALTIMORE, MD.								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY										
				ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) →														
e. Pneumonia DUE TO (OR AS A CONSEQUENCE OF):														
b. Pulmonary Tuberculosis DUE TO (OR AS A CONSEQUENCE OF):														
c. Acquired Immunodeficiency Syndrome DUE TO (OR AS A CONSEQUENCE OF):														
d.														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
Renal failure														
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>														
26. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one)												
HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 9 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 10 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER George E. Wicks III M.D.		29c. LICENSE NUMBER D41365		29d. DATE SIGNED (Month, Day, Year) June 24, 1995										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George E. Wicks III M.D. 2600 Liberty Heights Ave 21215														
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE John Anderson, R.R. #2												



95 19346

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH <small>REG. NO.</small>											
1. DECEDENT'S NAME (First, Middle, Last) <i>ESTHER DANIELS</i>													
4. SOCIAL SECURITY NUMBER <i>302-20-8228</i>		5. SEX <i>1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F</i>		6. AGE (In yrs. last birthday) <i>87 YRS.</i>		IF UNDER 1 YEAR <small>MONTHS DAYS</small>		IF UNDER 24 HRS. <small>HOURS MIN.</small>		2. DATE OF DEATH <small>MONTH DAY YEAR</small> <i>06 23 95</i>		3. TIME OF DEATH <i>0834 AM</i>	
9a. FACILITY NAME (If not Institution, give street and number) <i>UNIVERSITY HOSPITAL</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH <i>N/A</i>		7. DATE OF BIRTH <small>(Month, Day, Year)</small> <i>9/3/1907</i>		8. BIRTHPLACE (State or Foreign Country) <i>ALABAMA</i>					
RESIDENCE OF DECEDENT													
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <i>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</i>							
10e. STREET AND NUMBER <i>3523 DENNISON ROAD</i>				10f. ZIP CODE <i>21215</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
11. MARITAL STATUS <i>1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</i>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <i>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</i> <small>If YES, GIVE WAR OR DATES</small>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <i>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</i> <small>Specify:</small>		14. RACE — American Indian, Black, White, etc. <small>Specify:</small> <i>Black</i>							
15. DECEDENT'S EDUCATION <small>(Specify only highest grade completed)</small> <i>Elementary/Secondary (0-12) 8th</i>		16a. DECEDENT'S USUAL OCCUPATION <small>(Give kind of work done during most of working life. Do NOT use retired.)</small> <i>Domestic</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Housekeeping</i>									
17. FATHER'S NAME (First, Middle, Last) <i>WILLIAM BERRY</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ANNA (UNKNOWN)</i>									
19a. INFORMANT'S NAME (Type/Print) <i>REV. SIDNEY DANIELS</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3523 DENNISON ROAD BALTIMORE, MD. 21215</i>									
20a. METHOD OF DISPOSITION <i>1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Oakwood Cemetery</i>		DATE <i>6/30</i>		20c. LOCATION — City or Town, State <i>Warren, Ohio</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENCIATE <i>Leroy O. Dyett</i>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. SEPSIS</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>b. PNEUMONIA</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>c. END STAGE RENAL DISEASE</i>													
DUE TO (OR AS A CONSEQUENCE OF): <i>d. HYPERTENSION</i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <i>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</i>													
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <i>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <i>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</i>		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH		28a. DATE OF INJURY <small>(Month, Day, Year)</small>		28b. TIME OF INJURY <small>M</small>		28c. INJURY AT WORK? <i>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</i>		28d. DESCRIBE HOW INJURY OCCURRED					
<i>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide</i>		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER <i>1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</i>													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Susan D. Wolfthal</i>						29c. LICENSE NUMBER <i>D25575</i>		29d. DATE SIGNED (Month, Day, Year) <i>► 06-23-95</i>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SUSAN D. WOLFTHAL UNIV. OF MARYLAND 22 S. GREENE ST. BALTIMORE, MD 21201</i>													
31. DATE FILED (Month, Day, Year) <i>JUN 27 1995</i>		32. REGISTRAR'S SIGNATURE <i>John A. Williams, Randall</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

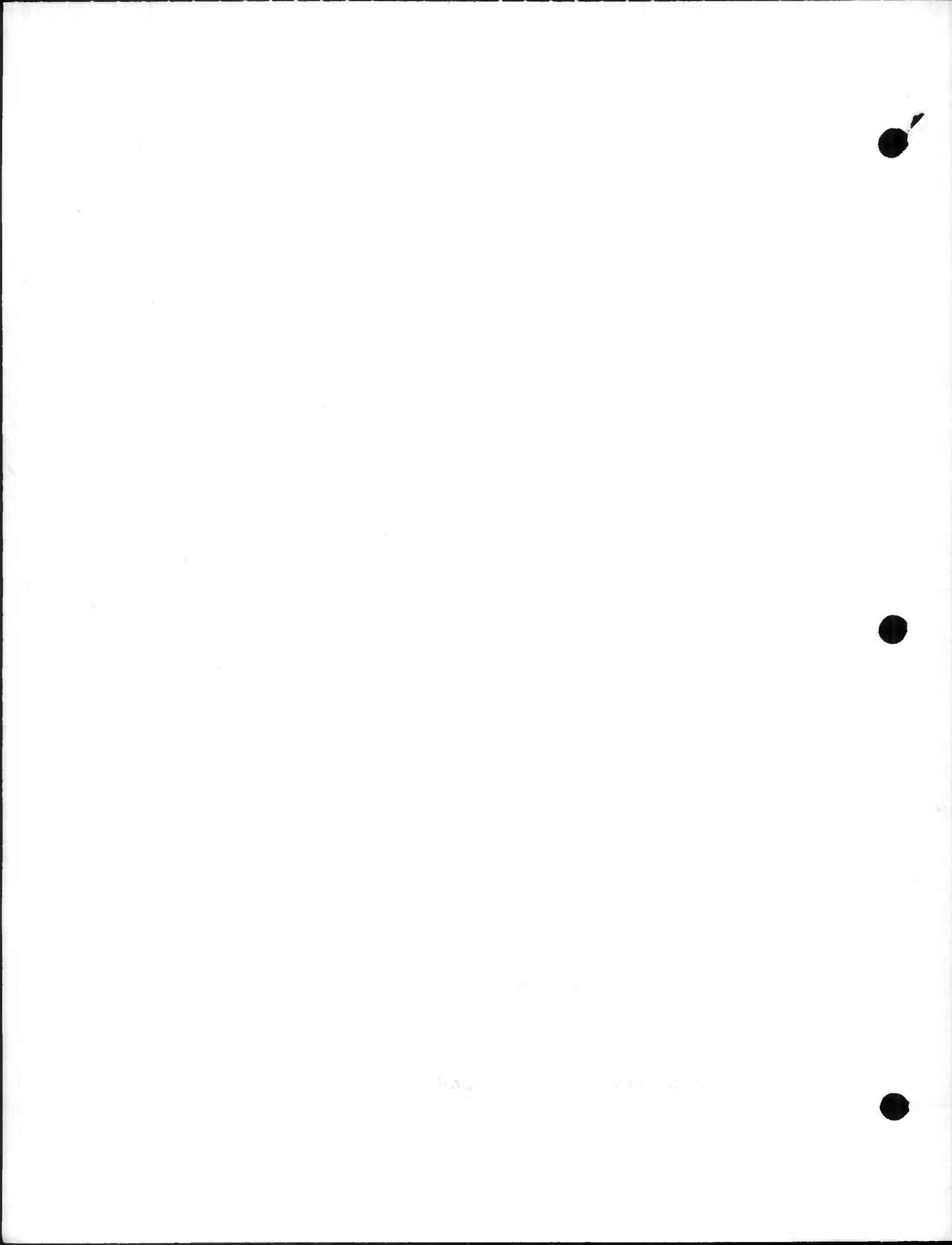
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR		Samuel H. DeHaven, Jr.								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 11:00 PM M			
1. DECEASED'S NAME (First, Middle, Last)		Samuel H. DeHaven, Jr.								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 11:00 PM M			
4. SOCIAL SECURITY NUMBER 212-07-0745		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 22, 1909		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 4336 Falls Road		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore								9c. COUNTY OF DEATH Baltimore City					
RESIDENCE OF DECEASED															
10a. STATE Maryland		10b. COUNTY Baltimore City		10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4336 Falls Road		10f. ZIP CODE 21211								10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white									
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Automotive Car Service		16b. KIND OF BUSINESS/INDUSTRY Chesapeake Cadillac Co.											
17. FATHER'S NAME (First, Middle, Last) Samuel H. DeHaven, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Magdalene Mack													
19a. INFORMANT'S NAME (Type/Print) Cindy Harrison		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 984 Rumsey Place Joppa, Maryland 21085													
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hilltop Service Co.		DATE 6/24		20c. LOCATION — City or Town, State Towson, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Tacey Henss Carpenter</i>		22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death Minutes			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>Acute Myocardial Infarct</i> DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		{ b. c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. Dean Drury</i>								29c. LICENSE NUMBER D23076		29d. DATE SIGNED (Month, Day, Year) ► 6-23-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RICHARD D. DRURY</i>		31. DATE FILED (Mo. Day Year) JUN 2 7 1995								32. REGISTRAR'S SIGNATURE <i>Jeanne Jackson-Parkell</i>					



95 19348

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 687600

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

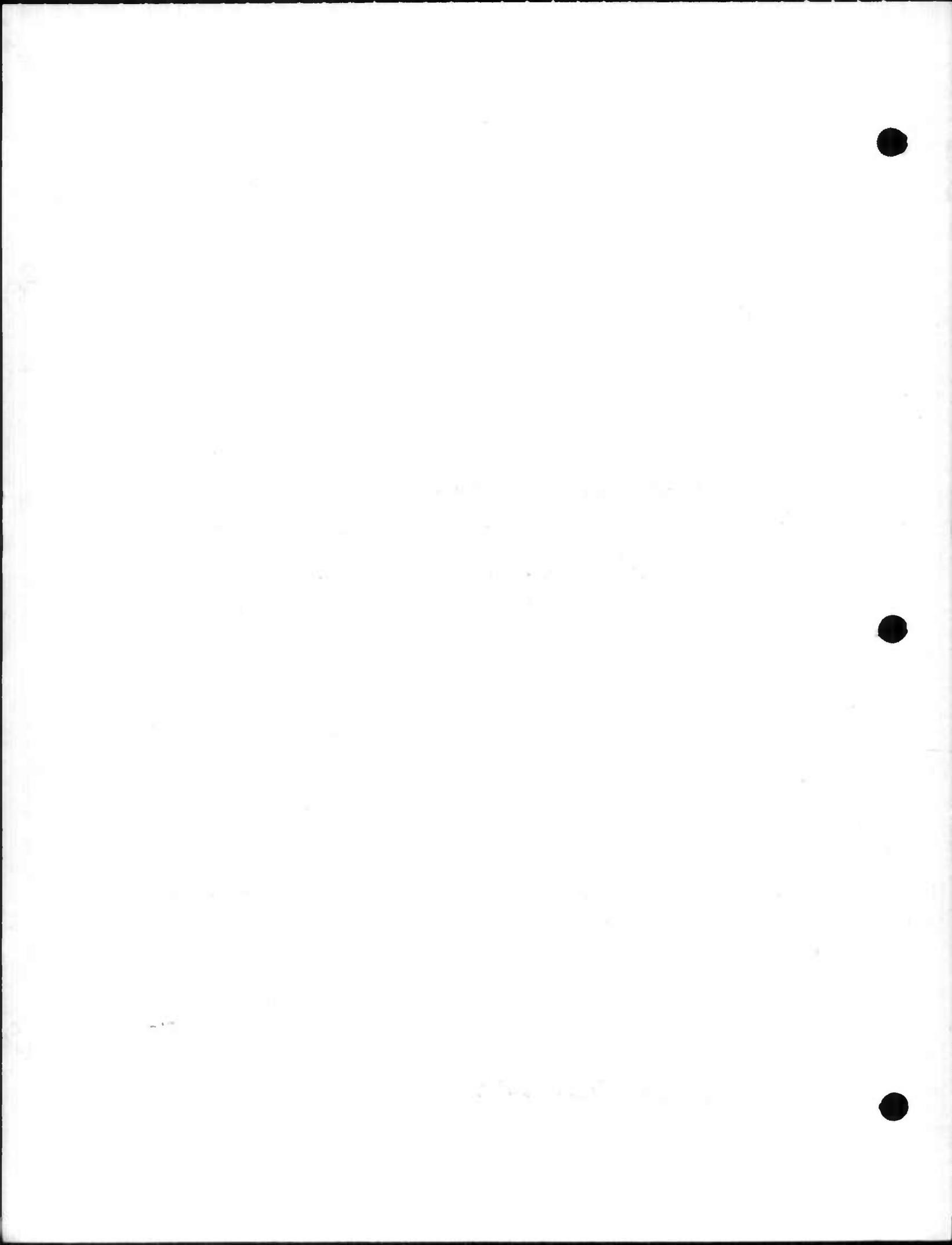
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		Gordon Derrenberger						2. DATE OF DEATH MONTH 6 DAY 25 YEAR 95		3. TIME OF DEATH 11.22 P.M.	
4. SOCIAL SECURITY NUMBER 216-22-3762		5. SEX <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS		IF UNDER 24 HRS. HOURS 0 MIN.		7. DATE OF BIRTH (Month, Day, Year) 3/25/28		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore						9c. COUNTY OF DEATH N/A			
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5125 Greenwich Ave.		10f. ZIP CODE 21229						10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Police Officer			16b. KIND OF BUSINESS/INDUSTRY Law Enforcement Baltimore City Police Dept.						
17. FATHER'S NAME (First, Middle, Last) William G. Derrenberger		18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna D. Hiskey									
19a. INFORMANT'S NAME (Type/Print) Maryanne Derrenberger		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5125 Greenwich Ave. Baltimore, Maryland 21229									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crownsville VA Cemetery			DATE 6/28		20c. LOCATION — City or Town, State Crownsville, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David J. Weber</i>		22. NAME AND ADDRESS OF FACILITY David J. Weber Funeral Home 5311 Edmondson Ave. Baltimore, Md. 21229									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute MI										2 days	
b. Due to (or as a consequence of): coronary artery disease										10 years	
c. Due to (or as a consequence of): congestive heart failure										1 year	
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>V. Dr. Maryanne</i> RESIDENT MEDICINE		29c. LICENSE NUMBER AD8125				29d. DATE SIGNED (Month, Day, Year) ► 6/26/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LIA DERRENBERGER, SAINT AGNES HOSPITAL 900 CATON AVE., BALTIMORE MD 21229											
31. DATE FILED (Month, Day, Year) 6/26 JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Julin Shuler Rodell</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

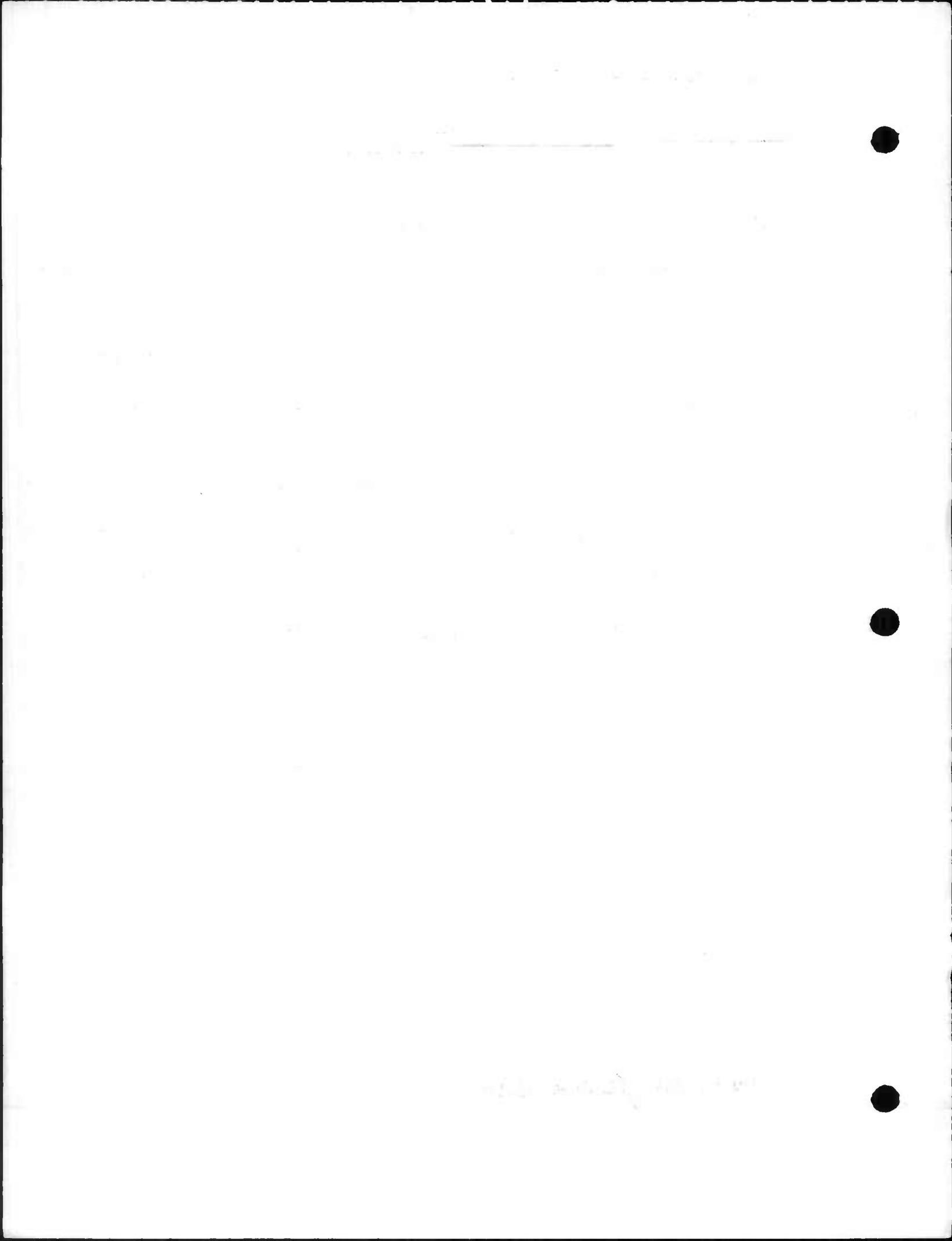
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEASED'S NAME (First, Middle, Last)		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.			
<u>DENNIS</u>		<u>WALLACE</u> WALLACE L. DENNIS						2. DATE OF DEATH MONTH <u>6</u> DAY <u>23</u> YEAR <u>95</u>	3. TIME OF DEATH <u>5 P.M.</u>		
4. SOCIAL SECURITY NUMBER <u>229-18-1343</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>80</u> YRS.	IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u>		IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u>		7. DATE OF BIRTH (Month, Day, Year) <u>2/19/1915</u>	8. BIRTHPLACE (State or Foreign Country) <u>VIRGINIA</u>		
9a. FACILITY NAME (If not institution, give street and number) <u>BEST</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>						9c. COUNTY OF DEATH <u>N/A</u>			
10a. STATE <u>MD</u>		10b. COUNTY <u>RANDALLSTOWN</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore County</u>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <u>3408 BARGAS CIRCLE B1</u>						10f. ZIP CODE <u>21207</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify				14. RACE — American Indian, Black, White, etc. Specify <u>BLACK</u>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>5TH</u>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>MACHINE OPERATOR</u>				16b. KIND OF BUSINESS/INDUSTRY <u>GENERAL Refinery</u>					
17. MOTHER'S NAME (First, Middle, Last) <u>ROBERT DENNIS</u>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>CATHERINE DENNIS</u>									
19a. INFORMANT'S NAME (Type/Print) <u>Wallace Dennis Jr.</u>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3700 CEDAR DRIVE Randallstown MD 21207</u>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>CEDAR HILL</u>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or crematory or other place) <u>CEDAR HILL</u> <u>2/26/95</u>				20c. DATE <u>2/26/95</u>		20d. LOCATION — City or Town, State <u>GLEN BURNIE MD</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSURE <u>John J. March</u>		22. NAME AND ADDRESS OF FUNERAL HOME <u>GARY J. MARCH FUNERAL HOME P.A.</u>									
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		e. <u>Cancer of prostate with metastases</u> DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>(2) diabetes mellitus</u> <u>(2) seizure disorder</u>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residential <input type="checkbox"/> Other (Specify) <u></u>						27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year) <u>6/26/95</u>			
29b. SIGNATURE AND TITLE OF CERTIFIER <u>A. AHMED M.D.</u>		29c. LICENSE NUMBER <u>D39127</u>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>A. AHMED M.D. 300 armory place Baltimore MD 21201</u>											
31. DATE FILED (Month, Day, Year) <u>JUN 27 1995</u>		32. REGISTRAR'S SIGNATURE <u>John J. March</u>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

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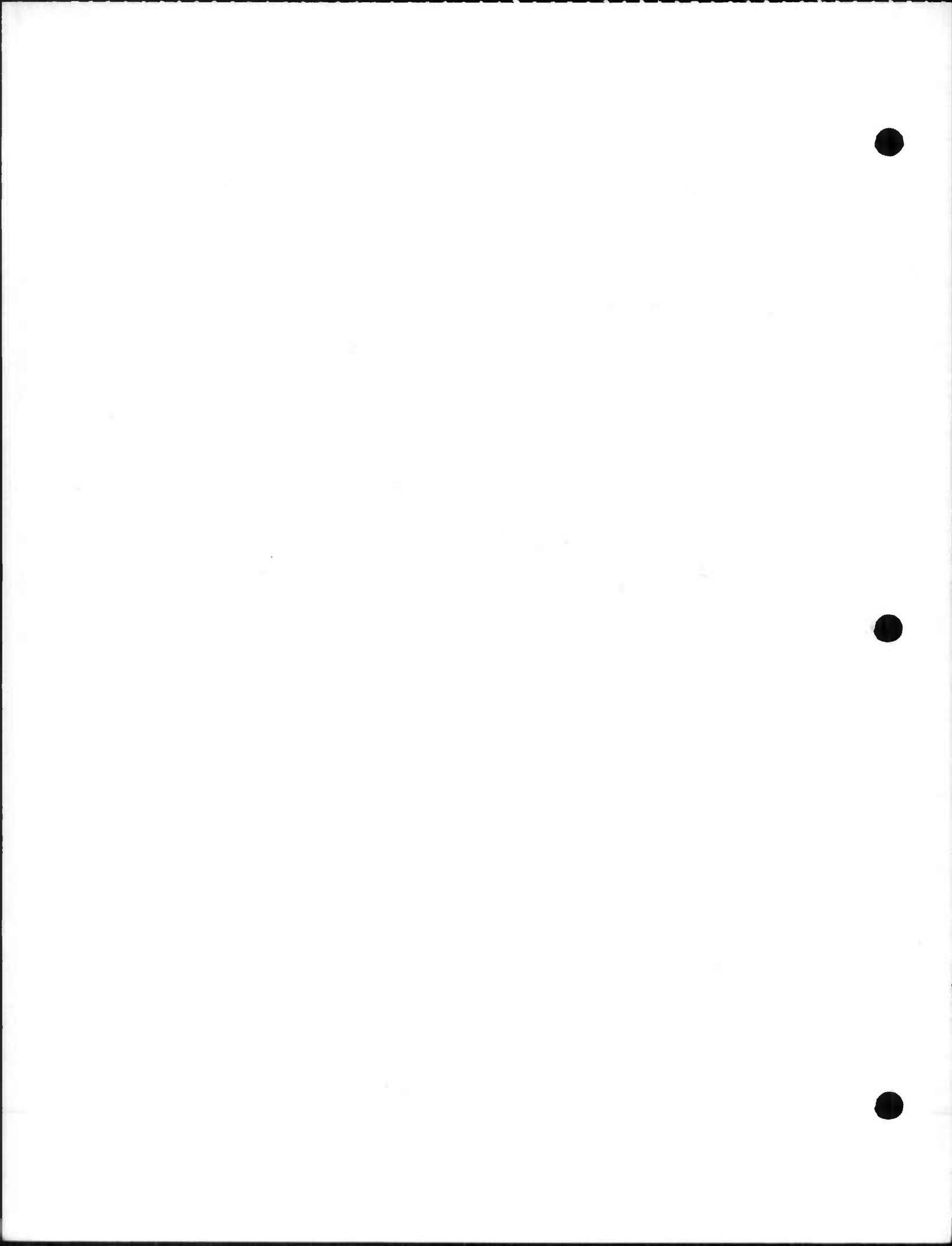
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1. FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR JUNE 25, 1995									3. TIME OF DEATH 17:55 PM					
1. DECEASED'S NAME (First, Middle, Last) EVALYN L. DAHLE			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F			6. AGE (In yrs. last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) January 4, 1927			8. BIRTHPLACE (State or Foreign Country) North Carolina				
4. SOCIAL SECURITY NUMBER 220-24-4485			6. AGE (In yrs. last birthday) 68 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) January 4, 1927			8. BIRTHPLACE (State or Foreign Country) North Carolina						
9a. FACILITY NAME (If not institution, give street and number) THE UNION MEMORIAL HOSP.			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY			9c. COUNTY OF DEATH N/A											
10e. STATE Maryland			10b. COUNTY N/A			10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO								
10e. STREET AND NUMBER 3314 Rosalie Avenue						10f. ZIP CODE 21234			10g. CITIZEN OF WHAT COUNTRY? United States								
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify:								
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Office Manager											
17. FATHER'S NAME (First, Middle, Last) Roy Capps						18. MOTHER'S NAME (First, Middle, Maiden Surname) Blanche Eva Medler											
19a. INFORMANT'S NAME (Type/Print) Mr. Elkins W. Dahle, Jr.						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3314 Rosalie Avenue Baltimore, Md. 21234											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Parkwood Cemetery			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6/30/95			DATE			20c. LOCATION — City or Town, State Baltimore, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavoina			22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc.			23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Overwhelming Septic Shock			Approximate Interval Between Onset and Death 1 min								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			a. DUE TO (OR AS A CONSEQUENCE OF): Overwhelming Septic Shock			b. DUE TO (OR AS A CONSEQUENCE OF):			c. DUE TO (OR AS A CONSEQUENCE OF):			d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal Failure, Liver Failure												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH Natural <input type="checkbox"/> Pending Investigation Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined Homicide <input type="checkbox"/>			28a. DATE OF INJURY (Month, Day, Year) 6/27/95			28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED At home, farm, street, lecture, office building, etc. (Specify)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER PAUL R. LUCAS, M.D.			29c. LICENSE NUMBER AT2438946-150			29d. DATE SIGNED (Month, Day, Year) JUNE 25, 1995								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul R. Lucas, M.D.			32. REGISTRAR'S SIGNATURE John Shuler-Rodell														
31. DATE FILED (Month, Day, Year) JUNE 25, 1995			32. REGISTRAR'S SIGNATURE John Shuler-Rodell														



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

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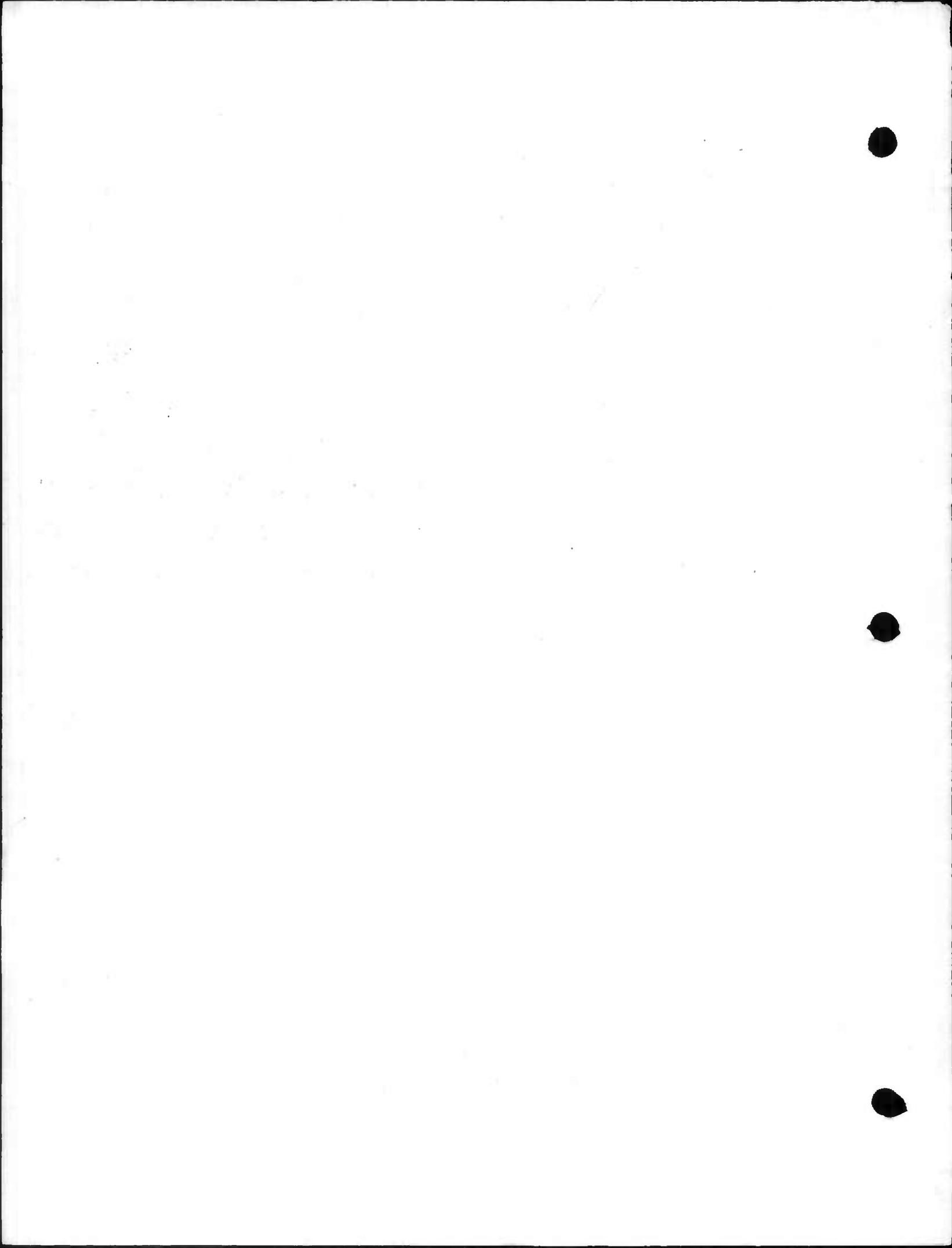
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) Robert Ellison												2. DATE OF DEATH MONTH DAY YEAR June 25, 1995	3. TIME OF DEATH 2:50 A.M.
4. SOCIAL SECURITY NUMBER 247-32-2459			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 28, 1922			8. BIRTHPLACE (State or Foreign Country) S.C.	
9a. FACILITY NAME (If not institution, give street and number) Frederick Villa Nursing Center						9b. CITY, TOWN OR LOCATION OF DEATH Catonsville						9c. COUNTY OF DEATH Baltimore Co.	
RESIDENCE OF DECEASED												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA					
10e. STREET AND NUMBER 3413 W. Caton Ave.													
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942-1946			13. WAS DESCENDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver				16b. KIND OF BUSINESS/INDUSTRY Transportation					
17. FATHER'S NAME (First, Middle, Last) John P. Ellison						18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie Johnson							
19a. INFORMANT'S NAME (Type/Print) Victoria Moore						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3413 W. Caton Ave., Balto. Md. 21229							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Garrison Forest 928/25 Owings Mills, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Russ						22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto. Md. 21216							
23. PART I. Enter the diseases, Dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												72 Years	
a. Cirrhosis of Liver DUE TO (OR AS A CONSEQUENCE OF):												Years	
b. Alcoholism DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			26. PLACE OF DEATH (Check only one)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year) 6/25/95		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED fall from bed			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) At home			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Ellicott City, MD 21042										
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. LICENSE NUMBER D 30469.									29d. DATE SIGNED (Month, Day, Year) June 27 1995.	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 9055, Chevrolet Dr; #Suite 100, Ellicott City, MD 21042.												DNMN-16 Rev 1/89	
31. DATE FILED (Month, Day, Year) JUN 27 1995													

3+1



DIVISION OF VITAL RECORDS, P.O. BOX 68760

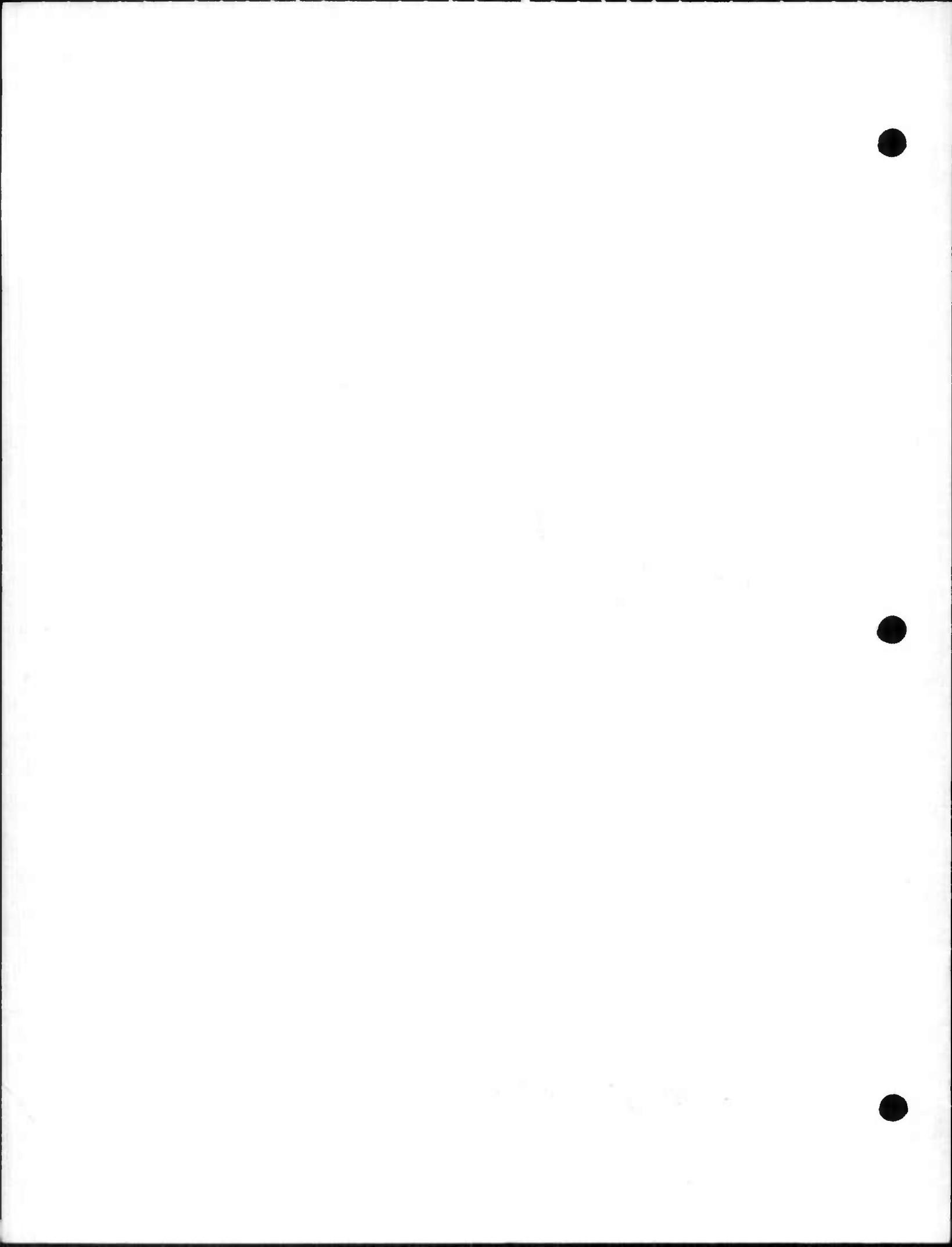
BALTIMORE, MARYLAND 21215-0020

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19352

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
		1. DECEASED'S NAME (First, Middle, Last)					2. DATE OF DEATH MONTH DAY YEAR			3. TIME OF DEATH M	
		<i>BUTCH E. EVANS</i>					<i>JUNE 22, 1995</i>			<i>2005</i>	
		4. SOCIAL SECURITY NUMBER 216-12-8656		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 22, 1922	
										8. BIRTHPLACE (State or Foreign Country) MARYLAND	
		9a. FACILITY NAME (If not institution, give street and number) North Arundel 301 Hospital Dr.		21061		9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie		9c. COUNTY OF DEATH Anne Arundel			
		RESIDENCE OF DECEASED									
		10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Glen Burnie		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
		10e. STREET AND NUMBER 21 Rosedale Avenue				10f. ZIP CODE 21061			10g. CITIZEN OF WHAT COUNTRY? United States		
		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white		
		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Insurance adjuster		16b. KIND OF BUSINESS/INDUSTRY Insurance					
		17. FATHER'S NAME (First, Middle, Last) Winton Mabe				18. MOTHER'S NAME (First, Middle, Maiden Surname) Theresa Spindler					
		19a. INFORMANT'S NAME (Type/Print) Joan McIntyre				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 802 Woodsdale Road Catonsville, 21228					
		20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery		DATE 6/26		20c. LOCATION — City or Town, State Glen Burnie, Maryland			
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home 1328 Sulphur Spring Road Arbutus 21227					
		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE DUE TO (OR AS A CONSEQUENCE OF): b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. VALVULAR AND HYPERTENSIVE HEART DISEASE 5 years DUE TO (OR AS A CONSEQUENCE OF): d. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 1 week									
		Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Myocardial Infarction, cerebral vascular accident									
		DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAN H. SCHLEIBFEDER, MD		31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>		33. LICENSE NUMBER 1128221		34. DATE SIGNED (Month, Day, Year) June 22, 1995			



DIVISION OF VITAL RECORDS, P.O. BOX 6876C

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

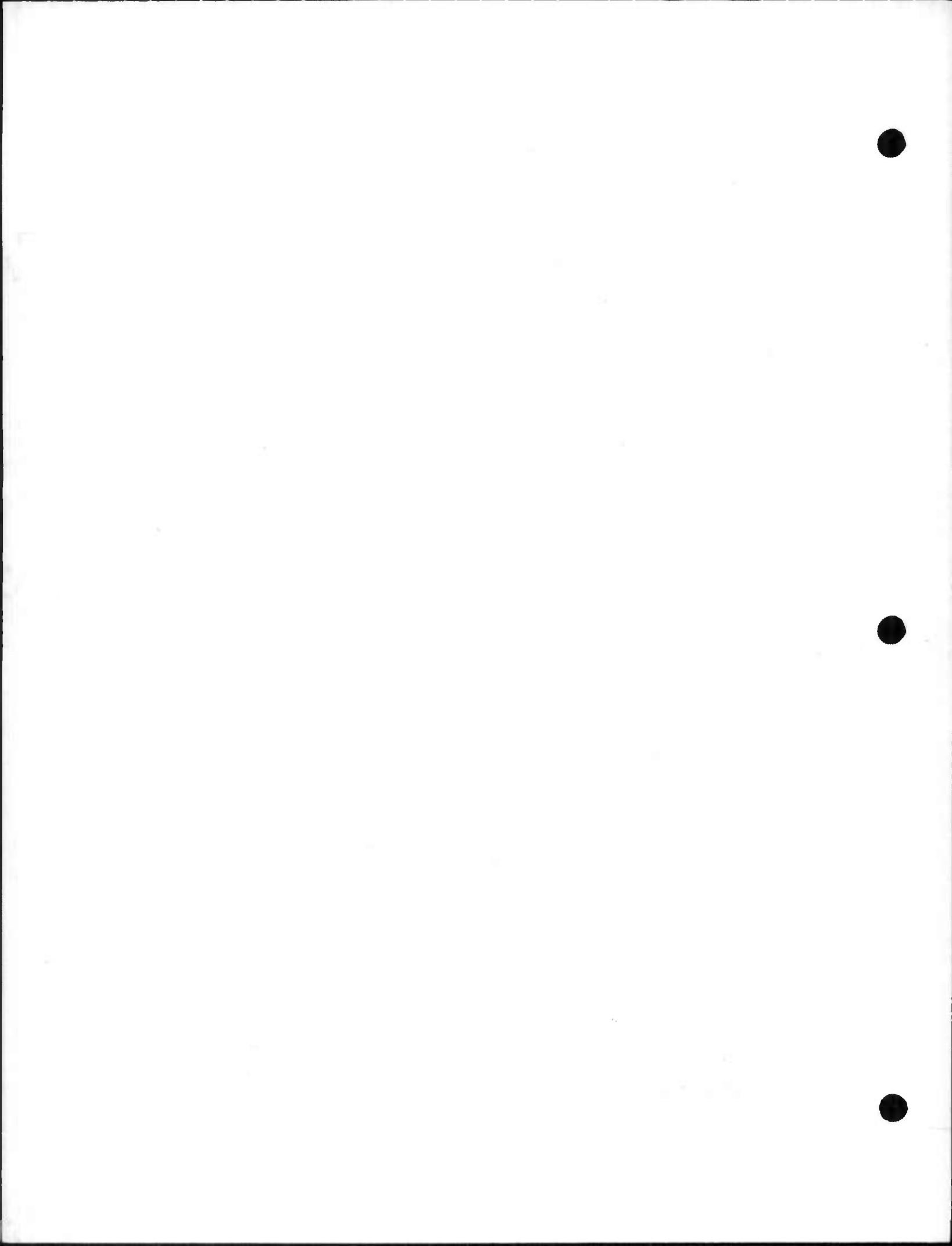
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH <i>11:30P M</i>			
1. DECEASED'S NAME (First, Middle, Last) Goldie Marie Elste										7. DATE OF BIRTH (Month, Day, Year) Oct. 2, 1918	8. BIRTHPLACE (State or Foreign Country) West Virginia		
4. SOCIAL SECURITY NUMBER 235-38-1709		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. HOURS	MIN.	9. CITY, TOWN OR LOCATION OF DEATH Middle River		9c. COUNTY OF DEATH Baltimore				
9a. FACILITY NAME (If not institution, give street and number) 3723 Apt. B White Pine Road										10a. STATE Md.	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Middle River	10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 3723 Apt. B White Pinr Road										10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND Specify: White				14. RACE — American Indian, Black, White, etc. Specify:			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY own home							
17. FATHER'S NAME (First, Middle, Last) John Henry Witt										18. MOTHER'S NAME (First, Middle, Maiden Surname) Bertie Lee Javins			
19a. INFORMANT'S NAME (Type/Print) Linda Williams										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 Spring Lane Baltimore Md. 21221			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holly Hill Cemetery				DATE 6/26/95	20c. LOCATION — City or Town, State Baltimore Md.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. Jerry Connally</i>										22. NAME AND ADDRESS OF FACILITY Connally Funeral Home of Essex 300 Mace Ave. Baltimore Md. 21221			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death			
a. <i>Atherosclerotic Cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):													
b. _____ DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial fibrillation</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND	28d. DESCRIBE HOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D31008				29d. DATE SIGNED (Month, Day, Year) ► 6-23-95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>David B Peichert 9105 Franklin Sq, Dr Suite 206 Baltimore MD 21237</i>													
31. DATE FILED (Month, Day, Year) JUN 27 1995 July 1995		32. LEGAL SIGNATURE											



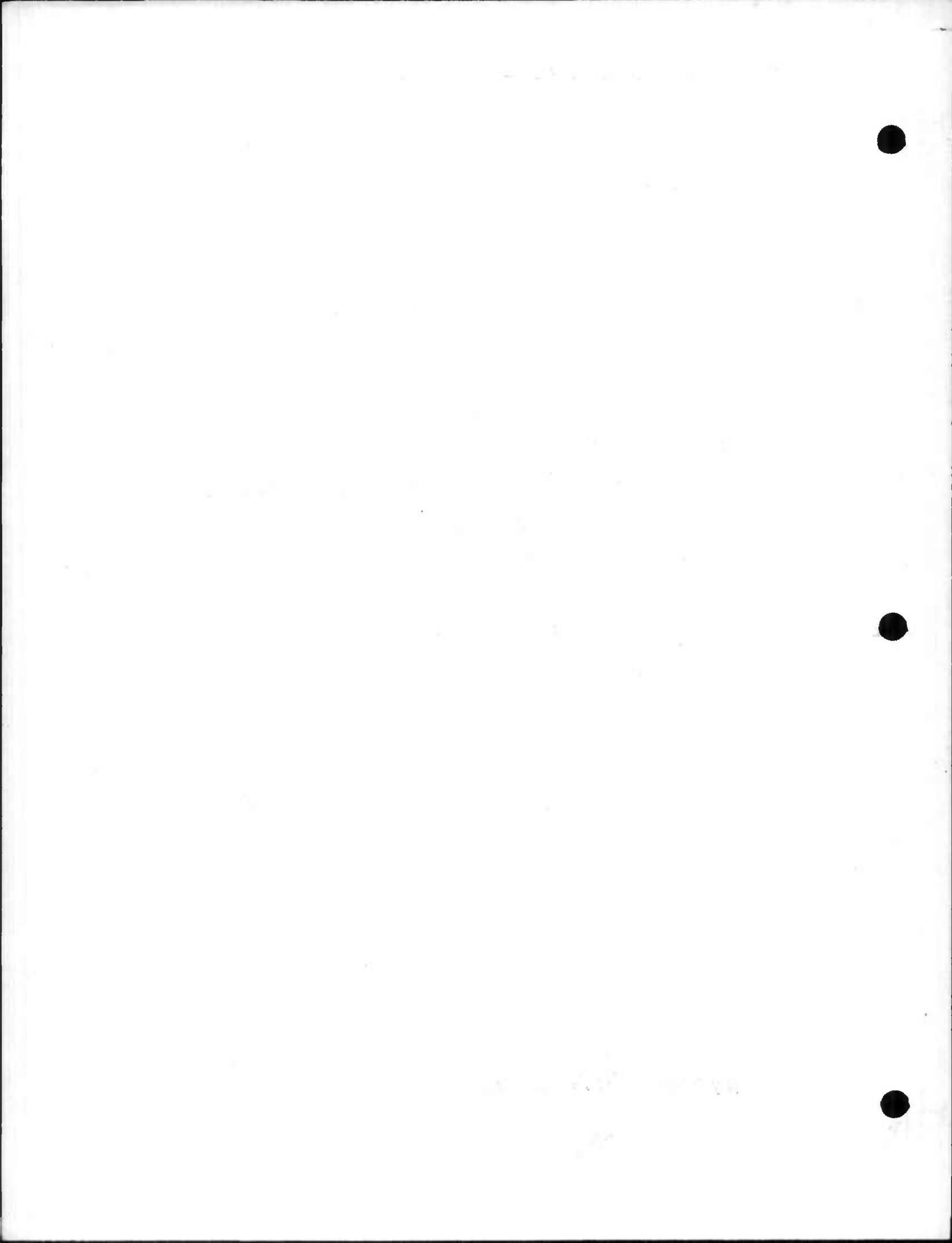
95 19354

ITEMS: 23 PART I, 27, PER MEO FILM G-724 6/27/95 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
DUANE LEROY ESTREET			JUNE 13 1995	8:07 AM
4. SOCIAL SECURITY NUMBER <u>217-66-8370</u>			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>40</u> YRS.
			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
9a. FACILITY NAME (If not institution, give street and number)			7. DATE OF BIRTH (Month, Day, Year) <u>Sept 16-54</u>	
KIMBROUGH ARMY HOSPITAL			8. BIRTHPLACE (State or Foreign Country) <u>Md</u>	
RESIDENCE OF DECEDENT			9c. COUNTY OF DEATH <u>ANNE ARUNDEL</u>	
10a. STATE <u>Md</u>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <u>ELLIOTT CITY</u>	10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>8751 Town and Country Blvd Apt E</u>			10f. ZIP CODE <u>21043</u>	10g. CITIZEN OF WHAT COUNTRY? <u>US</u>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Grocery Mgr</u>	16b. KIND OF BUSINESS/INDUSTRY <u>Food Service</u>	
17. FATHER'S NAME (First, Middle, Last) <u>Ronald J. Estreet</u>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Rebecca Owens</u>	
19a. INFORMANT'S NAME (Type/Print) <u>RONALD ESTREET</u>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2521 Arunah Ave Batt. Md 21216</u>	
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Disposition <input type="checkbox"/> Other (Specify) <u>METRO CEMETORY</u>			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, church, other place) <u>METRO CEMETORY</u>	DATE <u>6/20/95</u>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Univeral L. Bell</u>			22. NAME AND ADDRESS OF FACILITY <u>1721 N. Rock Funeral Service Monroe St.</u>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				
IMMEDIATE CAUSE (Final disease or condition resulting in death) → SUBARACHNOID HEMORRHAGE				
DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				
{ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29c. SIGNATURE AND TITLE OF CERTIFIER <u>John Locke MD</u>			29c. LICENSE NUMBER <u>O.C.M.E.</u>	29d. DATE SIGNED (Month, Day, Year) <u>JUNE 14, 1995</u>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>John Locke, MD</u> 111 Penn Street, Baltimore, Maryland 21201			31. DATE FILED (Month, Day, Year) <u>JUN 27 1995</u>	
32. REGISTRAR'S SIGNATURE <u>John Locke, MD</u>			DHMH-18 Rev 1/89	



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

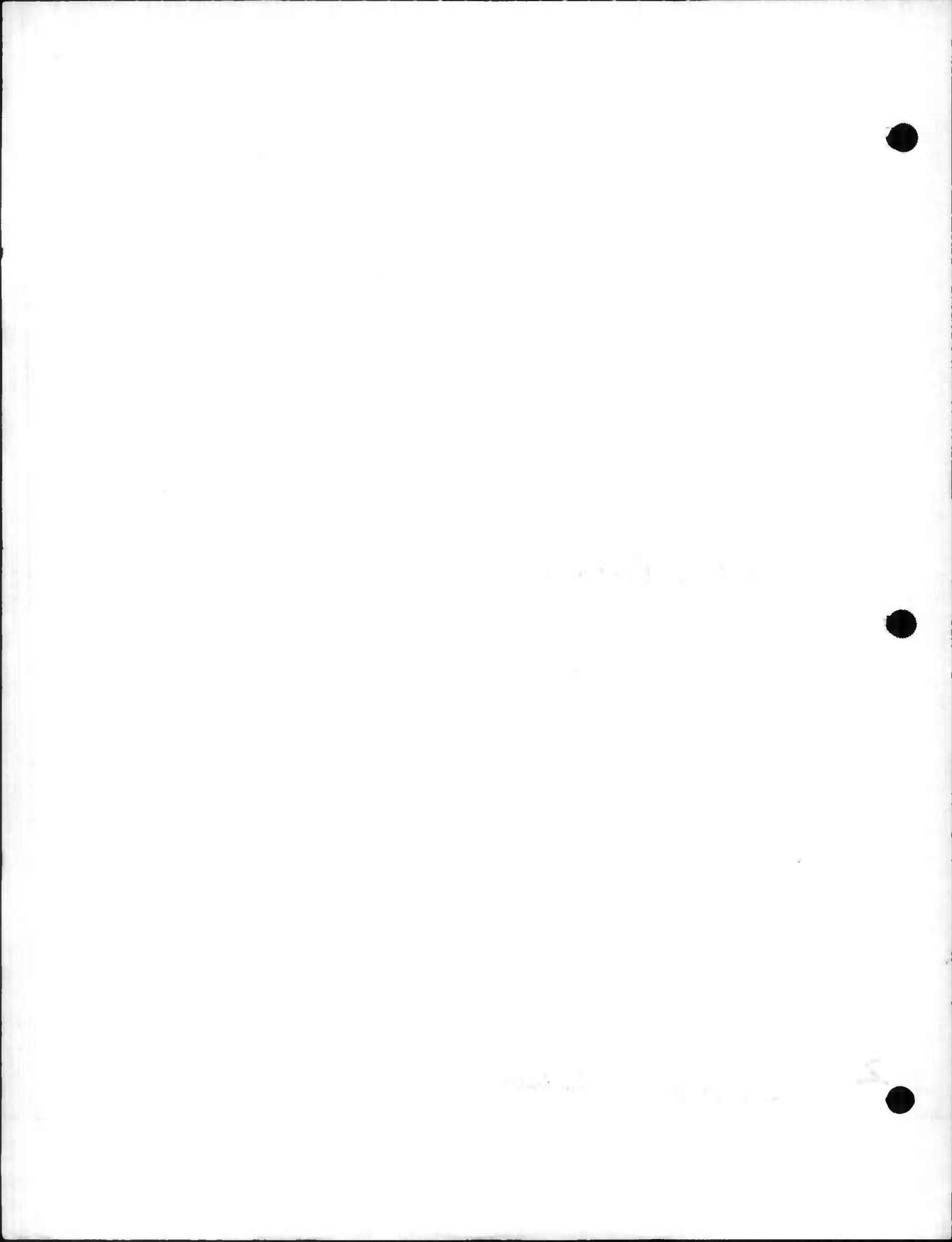
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) <i>Pauline J. Fraser</i>								2. DATE OF DEATH MONTH 06 DAY 22 YEAR 95	3. TIME OF DEATH 7:35 P.M.
4. SOCIAL SECURITY NUMBER 501 14 1743		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) APR 27, 1909	8. BIRTHPLACE (State or Foreign Country) Minnesota		
9e. FACILITY NAME (If not institution, give street and number) Knobwood Manor		9b. CITY, TOWN OR LOCATION OF DEATH Millersville						9c. COUNTY OF DEATH AACo	
RESIDENCE OF DECEASED									
10a. STATE Md	10b. COUNTY AACo	10c. CITY, TOWN OR LOCATION GAMBRILLS			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 951 Waugh Chapel ROAD				10f. ZIP CODE 21054			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) ----- Retail Clerk			16b. KIND OF BUSINESS/INDUSTRY Grocery				
17. FATHER'S NAME (First, Middle, Last) ----- Getting				18. MOTHER'S NAME (First, Middle, Maiden Surname) ----- UNK			19. MOTHER'S NAME (First, Middle, Maiden Surname) ----- UNK		
19e. INFORMANT'S NAME (Type/Print) Lorne G Fraser				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 951 Waugh Chapel Rd; Gambrills, Md 21054					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory			DATE 6/24/95	20c. LOCATION — City or Town, State Baltimore Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas Hardesty				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A.			12 Ridgely Ave. Annapolis, MD 21401		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
<p>a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Congestive heart failure</i></p> <p>b. { DUE TO (OR AS A CONSEQUENCE OF): c. { DUE TO (OR AS A CONSEQUENCE OF): d. {</p>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mirza M. Nusairre, M.D.</i>				29c. LICENSE NUMBER D40519			29d. DATE SIGNED (Month, Day, Year) ► 6.23.95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mirza M. Nusairre, M.D. 795 Aquahart Rd Glen Burnie MD									
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Jane Williams Roden</i>							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR <i>June 26 95</i>								3. TIME OF DEATH YEAR TIME <i>95 4:15 AM</i>					
1. DECEDENT'S NAME (First, Middle, Last)		Mary Ford													
<i>Ford, Mary</i>															
4. SOCIAL SECURITY NUMBER <i>213-07-6658</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>97 YRS.</i>		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. DATE OF BIRTH (Month, Day, Year) <i>March 04 1898</i>		9. BIRTHPLACE (State or Foreign Country) <i>Va. USA</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Hospital</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>								9c. COUNTY OF DEATH <i>N/A</i>					
10e. STATE <i>MD.</i>		10b. COUNTY <i>N/A</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>11 West 20th Street Apt. 2H</i>		10f. ZIP CODE <i>21218</i>								10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>6th</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i>								16b. KIND OF BUSINESS/INDUSTRY <i>Cook</i>					
17. FATHER'S NAME (First, Middle, Last) <i>George Winston</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rosa</i>													
19e. INFORMANT'S NAME (Type/Print) <i>Calvin P. Styles</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>3825 Sequoia Avenue Balto., MD. 21215</i>													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>MT. Auburn Cemetery</i>								DATE <i>6/29</i>		20c. LOCATION — City or Town, State <i>Balto., MD.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Doretha Hehn</i>		22. NAME AND ADDRESS OF FACILITY <i>CFSP #281</i>								1721-27 N. Monroe St		E.L. Phillips F/H Balto., MD. 21217			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death <i>1 day</i>			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Intracranial Bleeding</i>															
s. DUE TO (OR AS A CONSEQUENCE OF): <i>Intracranial Bleeding</i>															
b. DUE TO (OR AS A CONSEQUENCE OF): <i></i>															
c. DUE TO (OR AS A CONSEQUENCE OF): <i></i>															
d. DUE TO (OR AS A CONSEQUENCE OF): <i></i>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				26. PLACE OF DEATH (Check only one)		26. OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28e. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER <i>P-08571</i>										29d. DATE SIGNED (Month, Day, Year) <i>June 26, 1995</i>			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Shulman, MD</i>															
29c. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mercy Hospital 301 St Paul Place, Baltimore, MD,</i>															
31. DATE FILED (Month, Day, Year) <i>JUN 27 1995</i>		32. REGISTRAR'S SIGNATURE <i>Susan Shulman, R.R.</i>													

W.M. - 1975

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

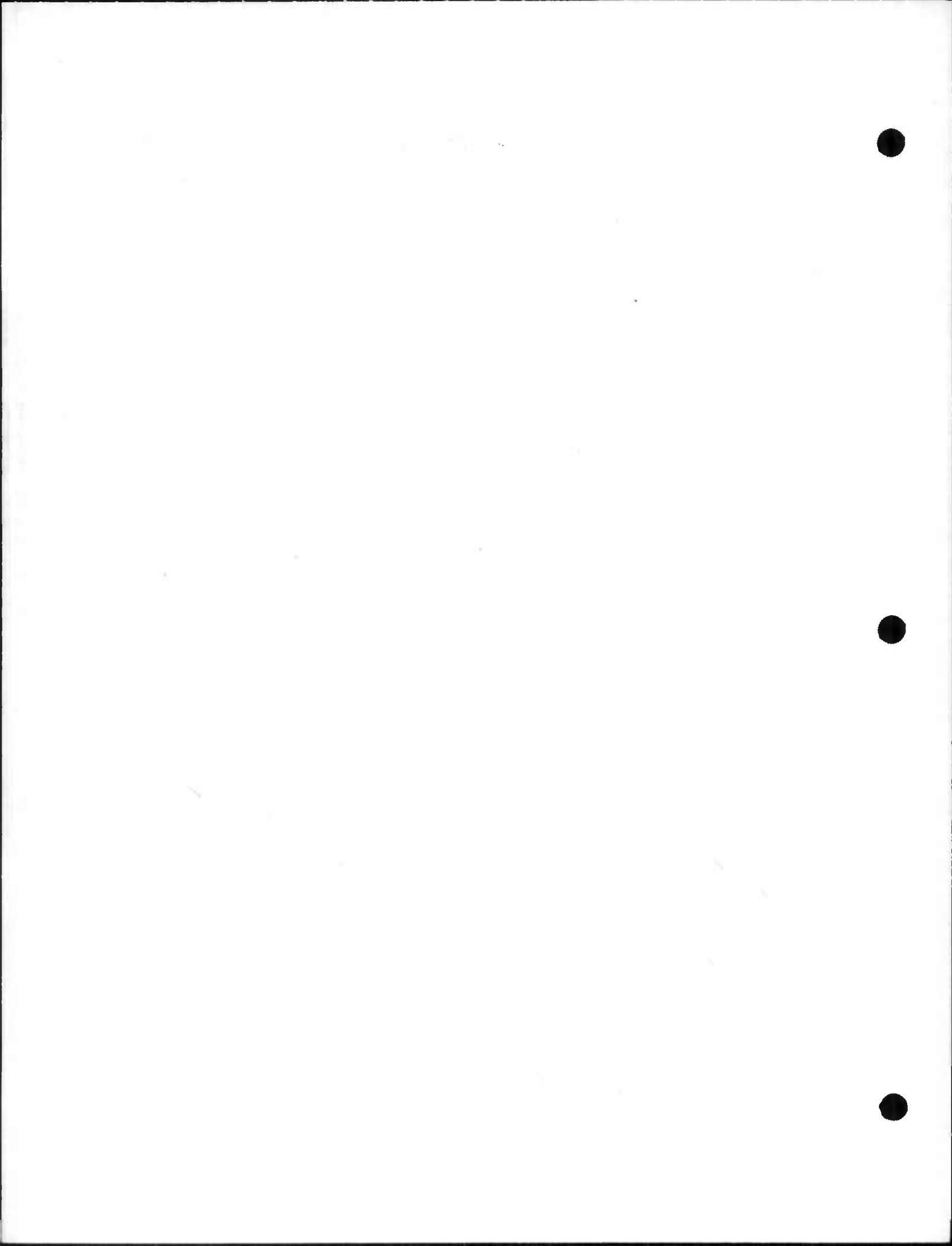
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)		William Francis Glover								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.				July 24, 1921	8. BIRTHPLACE (State or Foreign Country) Maryland		
219-05-0812		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	73 YRS.	MONTHS	DAYS	HOURS	MIN.						
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH								9c. COUNTY OF DEATH			
1831 Norfolk Road		Glen Burnie								Anne Arundel			
RESIDENCE OF DECEDENT													
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
Maryland	Anne Arundel	Glen Burnie											
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY? USA			
1831 Norfolk Road		21061											
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Brick Mason & Painter		16b. KIND OF BUSINESS/INDUSTRY Commercial Construction									
17. FATHER'S NAME (First, Middle, Last) Raymond Sylvester Glover		18. MOTHER'S NAME (First, Middle, Maiden Surname) Helen Nell Gill											
19a. INFORMANT'S NAME (Type/Print) Henrietta J. Glover		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1831 Norfolk Rd. Glen Burnie, MD 21061											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory, Inc. 6/26		DATE		20c. LOCATION — City or Town, State Baltimore, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE George E. MacNabb		22. NAME AND ADDRESS OF FACILITY Cremation Society of Md., Inc. 299 Frederick Rd. Balto., MD 21228											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cancer lung</i> DUE TO (OR AS A CONSEQUENCE OF)													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29f. SIGNATURE AND TITLE OF CERTIFIER <i>Charles J. Wu, M.D.</i>		29g. LICENSE NUMBER D18508		29d. DATE SIGNED (Month, Day, Year) ► June 26, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles J. Wu, M.D. 1600 S. Crain Highway Glen Burnie, MD 21061													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Julie Anderson</i>											



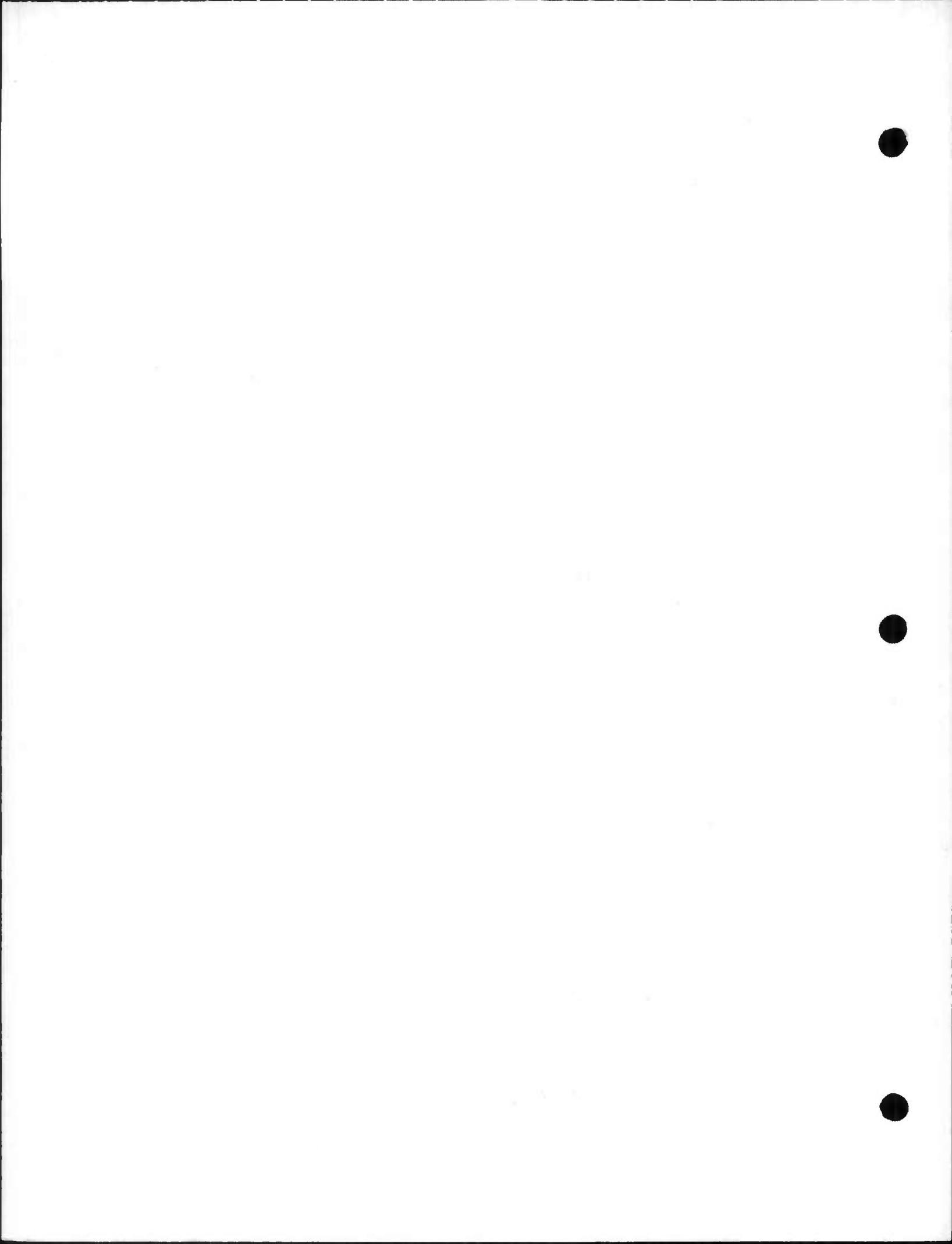
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 21, 1995										3. TIME OF DEATH 7:00p m			
1. DECEDENT'S NAME (First, Middle, Last) Jackie Dudley Guertin															
4. SOCIAL SECURITY NUMBER 483-26-7603		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 27, 1931		8. BIRTHPLACE (State or Foreign Country) Iowa					
9a. FACILITY NAME (If not institution, give street and number) 1211 West River Road												9b. CITY, TOWN OR LOCATION OF DEATH Shady Side		9c. COUNTY OF DEATH Anne Arundel	
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STATE MD		10f. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Shady Side		10f. ZIP CODE 20764		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+		16b. KIND OF BUSINESS/INDUSTRY Attorney											
17. FATHER'S NAME (First, Middle, Last) John Jacob Guertin		18. MOTHER'S NAME (First, Middle, Maiden Surname) Maude Mercier													
19a. INFORMANT'S NAME (Type/Print) Dorothy Guertin		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1211 West River Road, Shady Side, MD 20764													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Cemetery		20c. LOCATION — City or Town, State 6/24 Davidsonville, MD											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Thomas J Hardesty		22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 2140													
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. pancreatic cancer DUE TO (OR AS A CONSEQUENCE OF):												Approximate Interval Between Onset and Death			
b. DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence 5 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED									
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER J. Hardesty													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clinton, MD		31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE J. Hardesty		29c. LICENSE NUMBER D17601		29d. DATE SIGNED (Month, Day, Year) 6/28/95							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

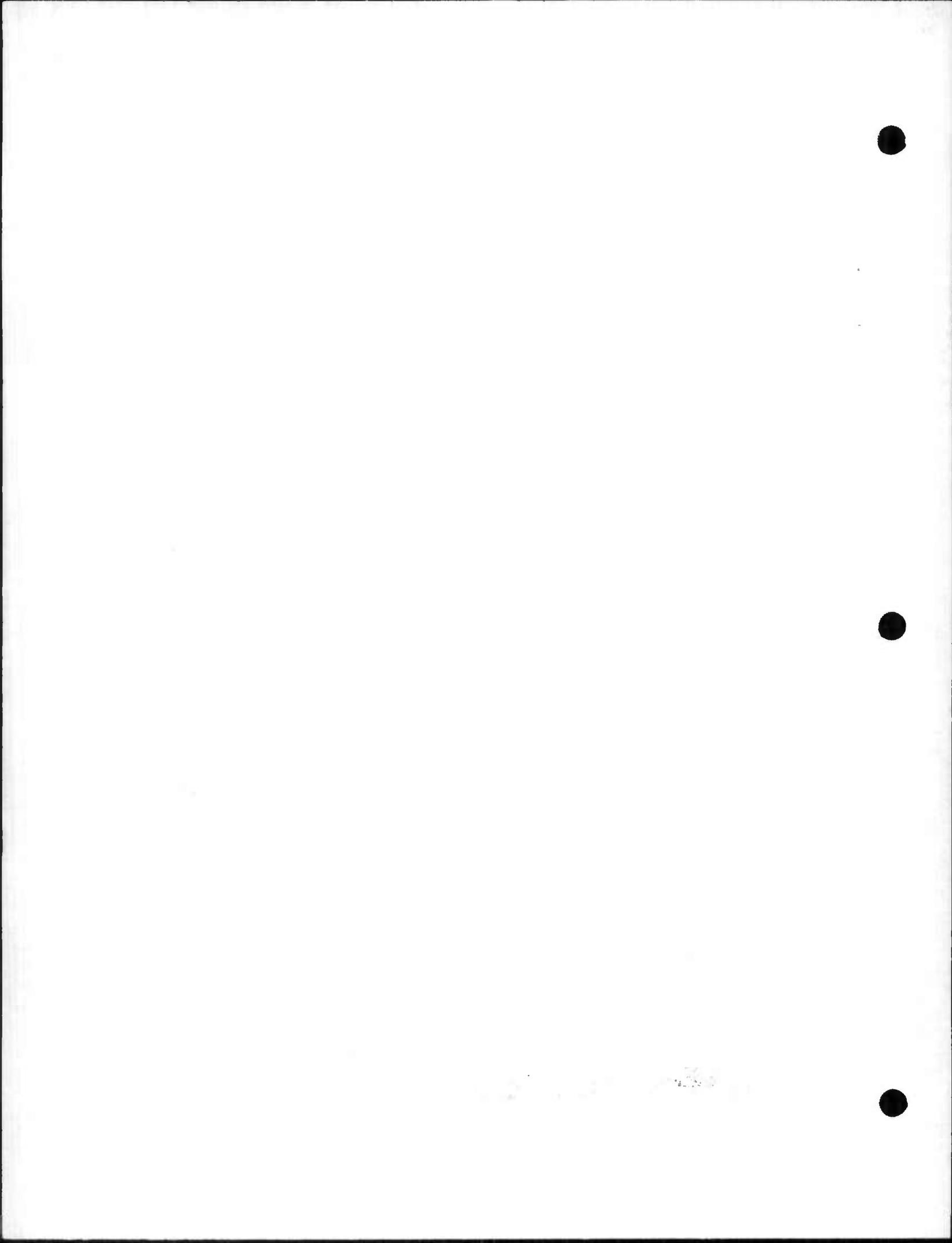
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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.					
1 - FOR STATE REGISTRAR		THERESA MARY GETTIER															
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 10:15 A M				
4. SOCIAL SECURITY NUMBER 219-16-4292												5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept 30, 1924	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) 3436 South Hanover St., 21225												9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH NA		
RESIDENCE OF DECEDENT																	
10a. STATE Maryland		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION Baltimore (Brooklyn)						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 3436 South Hanover St.						10f. ZIP CODE 21225			10g. CITIZEN OF WHAT COUNTRY? United States								
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Wire Assembler				16b. KIND OF BUSINESS/INDUSTRY Westinghouse											
17. FATHER'S NAME (First, Middle, Last) Harry Hart						18. MOTHER'S NAME (First, Middle, Maiden Surname) Susanna Dombrowski											
19a. INFORMANT'S NAME (Type/Print) Mr. John Louis Gettier						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3436 S. Hanover St., Baltimore, Md. 21225											
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Metro Crematory, Inc. 6/21/95						20c. LOCATION — City or Town, State Catonsville, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY McCullly Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 3 yrs					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																	
b. DUE TO (OR AS A CONSEQUENCE OF): EMPHYSEMA																	
c. DUE TO (OR AS A CONSEQUENCE OF):																	
d. DUE TO (OR AS A CONSEQUENCE OF):																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED						28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D 21776			29d. DATE SIGNED (Month, Day, Year) ► 6/19/95								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. S. P. Mundra, M.D. 203 E. Patapsco Ave., Balto., Md. 21225																	
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 															



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
IRVING GORDON												JUNE 22, 1995	10:45 AM M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
215-03-7707		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	85 YRS.	MONTHS	DAYS	HOURS	MIN.	DEC. 27, 1909		GERMANY			
9e. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH					
NORTHWEST HOSPITAL CENTER				RANDALLSTOWN				BALTIMORE					
RESIDENCE OF DECEDENT													
10e. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?			
MARYLAND	BALTIMORE	BALTIMORE								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
902 PAINTED POST ROAD				21208				USA					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPAIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+)				4 ENGINEER				GLENN L. MARTIN CORP.			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)									
BERKO GORDON				IDA				UNKNOWN					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
DR. JOEL S GORDON				8319 TURNBERRY COURT POTOMAC, MD 20854									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
				MTIKRO KODESH BETH ISRAEL				6-25-95		BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Alan Levinson</i>				22. NAME AND ADDRESS OF FACILITY									
				SOL LEVINSON & BROS., INC.									
				6010 REISTERSTOWN ROAD BALTIMORE, MD 21215									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												1 hr	
a. <i>Thoracic Aneurysm Rupture</i>												Yes.	
b. <i>HD Scud.</i>													
c. <i></i>													
d. <i></i>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jay S. Levinson</i>		29c. LICENSE NUMBER 008029				29d. DATE SIGNED (Month, Day, Year) ► 6/23/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JOSEPH BARTON DR. JAY S. LEVINSON</i>													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>John H. Schaefer</i>											

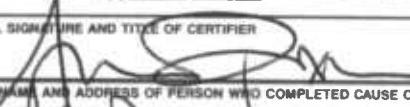
25

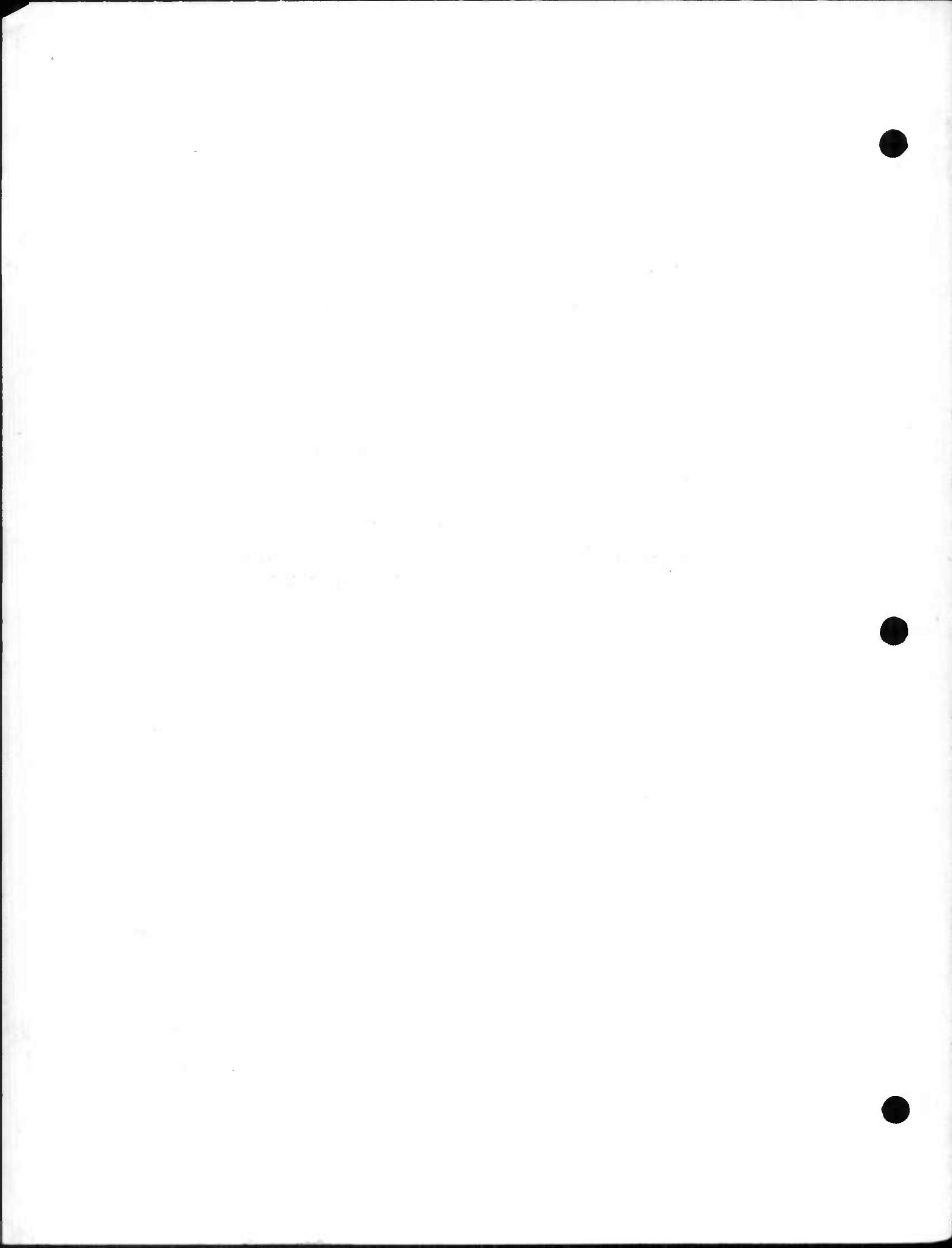
95 1936

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/24/95 t.t

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RONALD JOYNER				2. DATE OF DEATH MONTH JUNE DAY 23 YEAR 95 8:54 A.M.	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 218-46-6819		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				7. DATE OF BIRTH (Month, Day, Year) 09-22-47	
9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				8. BIRTHPLACE (State or Foreign Country) NEW YORK	
9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEDENT					
10a. STATE MD.	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 12 N. WOODINGTON ROAD			10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ROOFER		16b. KIND OF BUSINESS/INDUSTRY UNK	
17. FATHER'S NAME (First, Middle, Last) BOYKINS JOYNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALMENA BROOKS	
19a. INFORMANT'S NAME (Type/Print) YVONNE D. JOYNER			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 N. WOODINGTON ROAD BALTO. MD 21229		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORIAL 06-27-95		DATE	20c. LOCATION — City or Town, State CATONSVILLE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					
22. NAME AND ADDRESS OF FACILITY ALBERT P. WYLIE F/H PA 638 N. GILMOR STREET 21217					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. BLUNT HEAD INJURY WITH COMPLICATIONS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____					
Approximate Interval Between Onset and Death					
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input checked="" type="checkbox"/> Homicide	28a. DATE OF INJURY (Month, Day, Year) 5-15-95	28b. TIME OF INJURY UNKNOWN	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED SUBJECT WAS STRUCK ON HEAD	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT A BAR			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 1600 ABBOTSTON STREET BALTIMORE CITY, MD.		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29b. SIGNATURE AND TITLE OF CERTIFIER 		
29c. LICENSE NUMBER O.C.M.E.			29d. DATE SIGNED (Month, Day, Year) JUNE 24, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore, Maryland 21201					
31. DATE FILED (Month, Day, Year) JUN 21 1995			32. REGISTRAR'S SIGNATURE 		



95 19362

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) ROBERT		Sylvester JUMP				2. DATE OF DEATH MON Jun 20 DAY 1995 YEAR		3. TIME OF DEATH 4:25 pm	
4. SOCIAL SECURITY NUMBER 212-10-5752		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	HOURS 0	MIN. 0	7. DATE OF BIRTHN (Month, Day, Year) 8/30/08	8. BIRTHPLACE (State or Foreign Country) MARYLAND
9a. FACILITY NAME (If not institution, give street and number) Saint Joseph Medical Center		9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland				9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND	10b. COUNTY BALTIMORE	10c. CITY, TOWN OR LOCATION GLENDALE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1219 ST. ANDREWS WAY				10f. ZIP CODE 21239			10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5+ years			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: WHITE			14. RACE — American Indian, Black, White, etc. Specify:		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Design Engineer			16b. KIND OF BUSINESS/INDUSTRY Machinery				
17. FATHER'S NAME (First, Middle, Last) Charles H. Jump				18. MOTHER'S NAME (First, Middle, Maiden Surname) Grace Harvey					
19a. INFORMANT'S NAME (Type/Print) Mary Koziel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1219 St. Andrews Way Baltimore, MD 21239					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Parkwood Cemetery			20b. PLACE AND DATE OF DISPOSITION /Name of cemetery, crematory or other place/ Parkwood Cemetery			DATE 6/23/95	20c. LOCATION — City or Town, State Baltimore, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 									
22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21286									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. TRACTABLE CONGESTIVE HEART FAILURE									
b. DUE TO (OR AS A CONSEQUENCE OF): HYPERTENSIVE ARTERIOSCLEROTIC									
c. DUE TO (OR AS A CONSEQUENCE OF): CARDIOVASCULAR DISEASE									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. RENAL FAILURE DIABETES MELLITUS									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Beatrice P. Dixon, M.D.							
		29c. LICENSE NUMBER D16492							
		29d. DATE SIGNED (Month, Day, Year) June 20 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BEATRICE DIXON M.D. ST JOSEPH MEDICAL CENTER, TOWSON, MARYLAND 21204									
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Julin Shuler Ratliff							

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

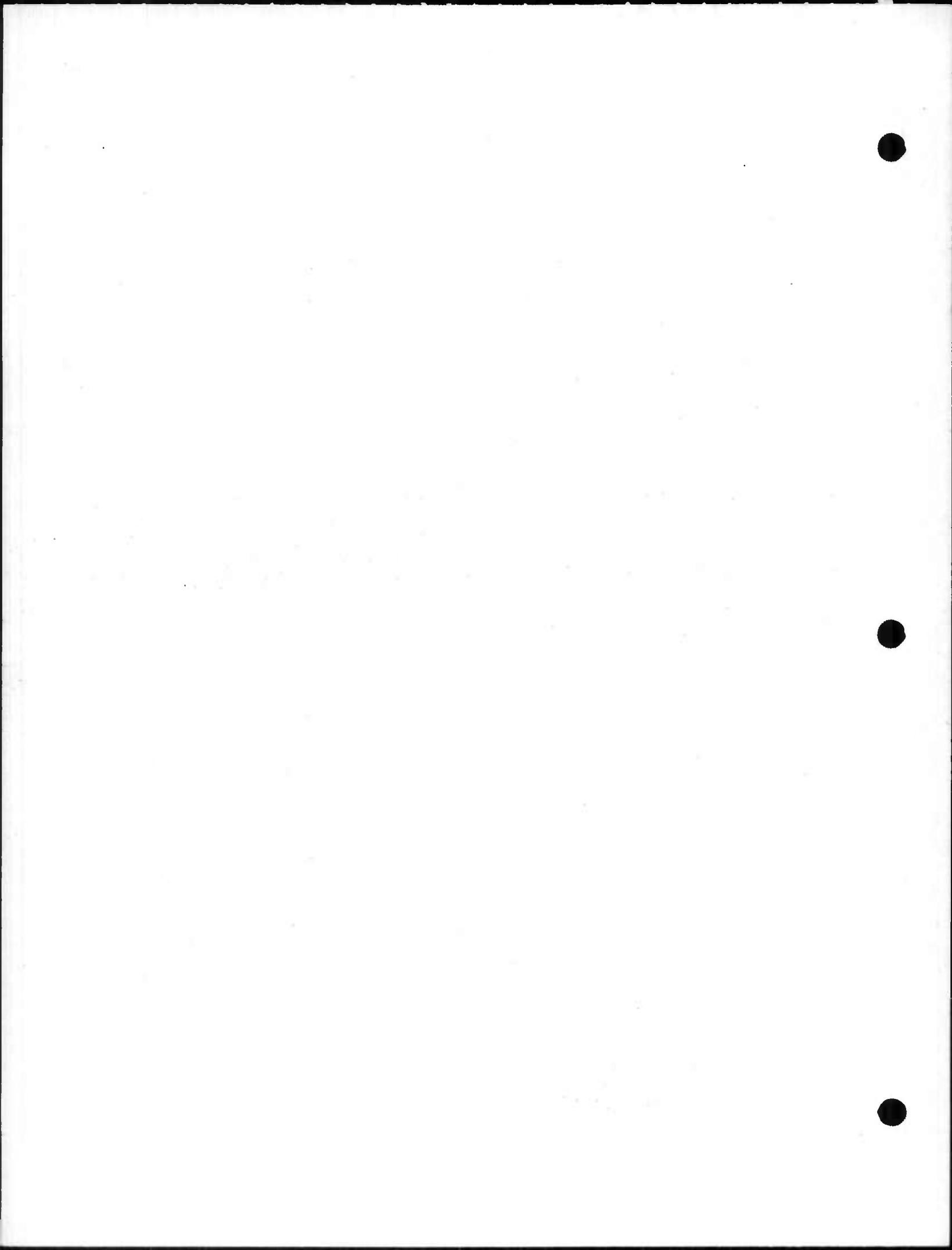
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 11:30 A.M.	
Lena M. Jester			June 24, 1995										
4. SOCIAL SECURITY NUMBER 218-05-9871		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 92 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.					7. DATE OF BIRTH (Month, Day, Year) Jan. 19, 1903				
9a. FACILITY NAME (If not institution, give street and number) Long Green Nursing Home			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore						8. BIRTHPLACE (State or Foreign Country) Maryland				
9c. COUNTY OF DEATH Baltimore City													
RESIDENCE OF DECEASED													
10a. STATE Maryland	10b. COUNTY Baltimore City	10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER 834 W. 36th Street				10f. ZIP CODE 21211			10g. CITIZEN OF WHAT COUNTRY? USA						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home								
17. FATHER'S NAME (First, Middle, Last) Jarrett Thompson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Savina Kemp									
19a. INFORMANT'S NAME (Type/Print) Dorothy Stollenmaier				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 834 W. 36th Street Baltimore, Maryland 21211									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial			DATE 6/27	20c. LOCATION — City or Town, State Cockeysville, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leanne Henss Carpenter</i>				22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death 1 week		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Stroke													
S. DUE TO (OR AS A CONSEQUENCE OF):													
b. DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary artery Disease													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)											
		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
<input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard J. Amund</i>		29c. LICENSE NUMBER D23676						29d. DATE SIGNED (Month, Day, Year) ► 6-26-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RICHARD J. AMUND 3730 Fall Rd Baltimore 21211													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Jeanine A. Kunkel-Randall</i>											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

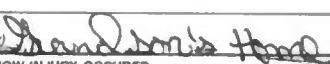
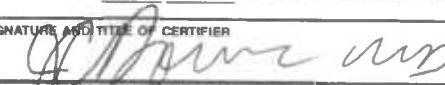
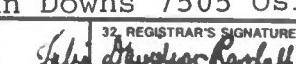
TO BE COMPLETED BY FUNERAL DIRECTOR

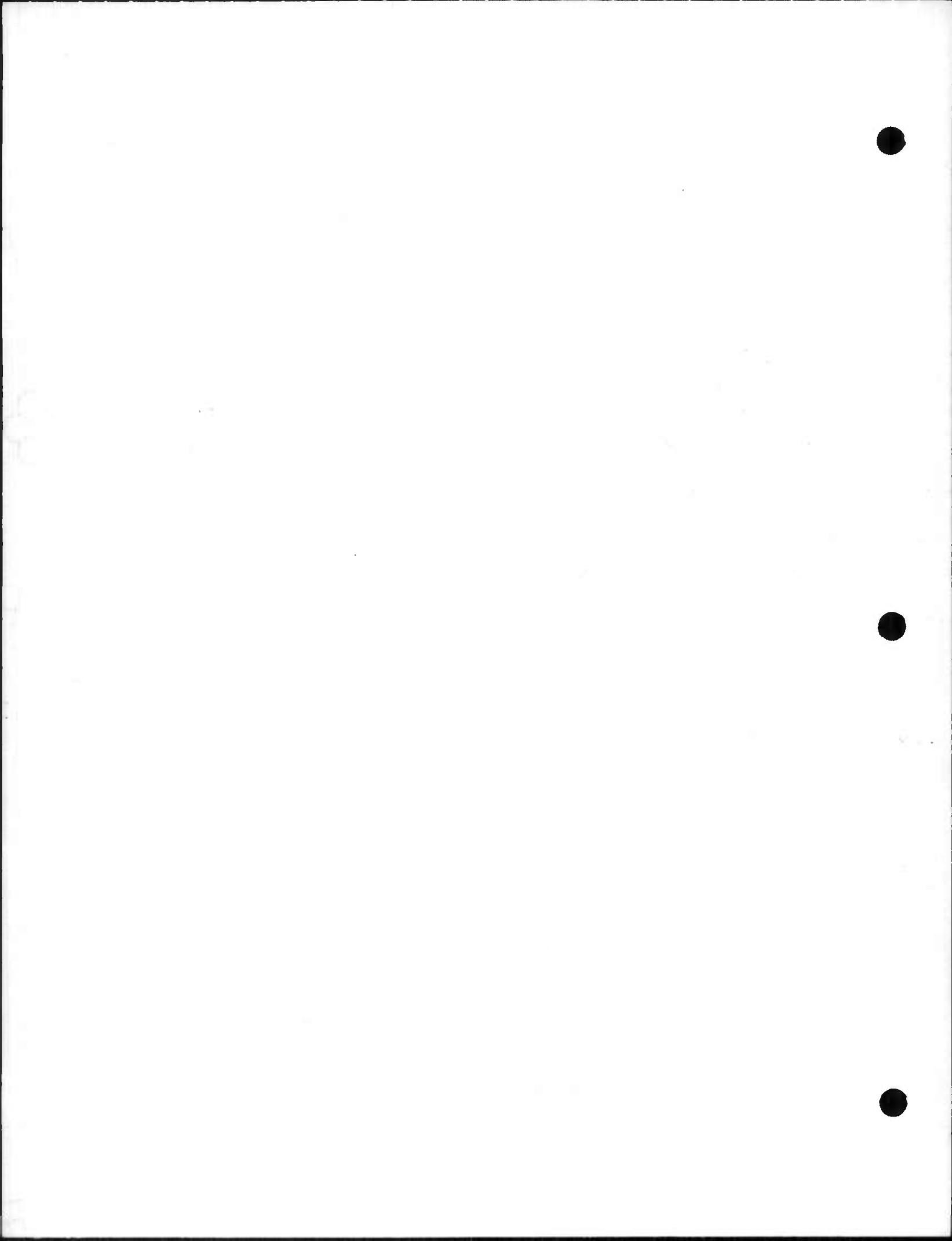
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19364

1. DECEDENT'S NAME (First, Middle, Last) NANCY HORNER JONES								2. DATE OF DEATH MONTH DAY YEAR 6 24 95	3. TIME OF DEATH 3:30 p.m.										
4. SOCIAL SECURITY NUMBER 217-24-7344				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 65 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) 8-22-29	8. BIRTHPLACE (State or Foreign Country) Maryland											
9a. FACILITY NAME (If not institution, give street and number) 2225 W. Joppa Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Lutherville				9c. COUNTY OF DEATH Baltimore											
RESIDENCE OF DECEDENT																			
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Lutherville						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
10e. STREET AND NUMBER 200 Dunbeath Ct.				10f. ZIP CODE 21093				10g. CITIZEN OF WHAT COUNTRY? U.S.A.											
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <input type="checkbox"/>			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <input type="checkbox"/>			14. RACE — American Indian, Black, White, etc. Specify: White											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 1 yr Housewife			16b. KIND OF BUSINESS/INDUSTRY Own Home														
17. FATHER'S NAME (First, Middle, Last) James K. Horner				18. MOTHER'S NAME (First, Middle, Maiden Surname) Irene Pepper															
19a. INFORMANT'S NAME (Type/Print) Katherine J. Page				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 505 Devonshire Lane Severna Park, Md. 21146															
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery			DATE 6-27	20c. LOCATION — City or Town, State Pikesville, Md.													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. Small Cell Lung Carcinoma Approximate Interval Between Onset and Death 1 year</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>{ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):</p>																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) 																	
27. MANNER OF DEATH <table border="0"><tr><td><input checked="" type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td></td></tr><tr><td><input type="checkbox"/> Suicide</td><td></td></tr><tr><td><input type="checkbox"/> Homicide</td><td></td></tr><tr><td>8 <input type="checkbox"/> Could not be determined</td><td></td></tr></table>		<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide		<input type="checkbox"/> Homicide		8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED			
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																		
<input type="checkbox"/> Accident																			
<input type="checkbox"/> Suicide																			
<input type="checkbox"/> Homicide																			
8 <input type="checkbox"/> Could not be determined																			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. LICENSE NUMBER D33624																	
29b. SIGNATURE AND TITLE OF CERTIFIER 		29d. DATE SIGNED (Month, Day, Year) 6/26/95																	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. John Downs 7505 Osler Dr. Towson, Md.																			
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 																	



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

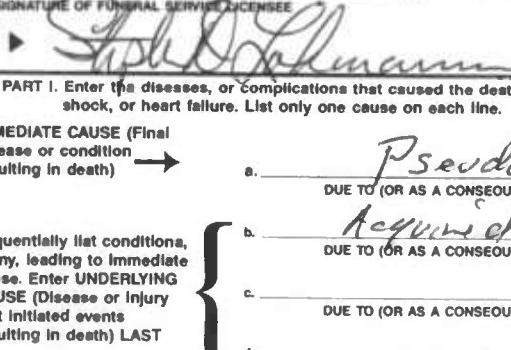
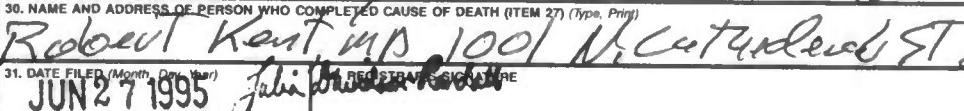
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

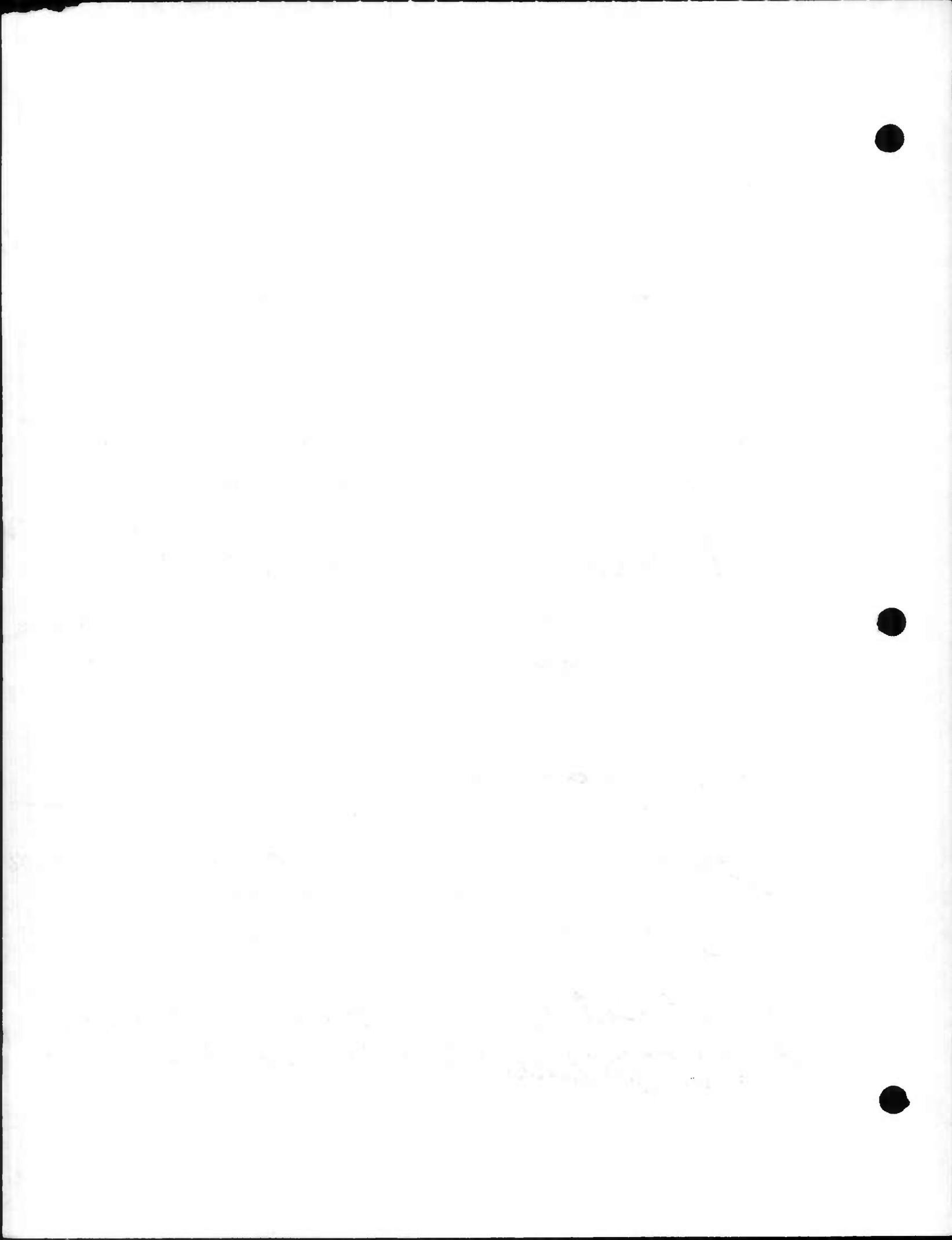
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH	3. TIME OF DEATH		
Michael Allen Jones										MONTH June	DAY 24	YEAR 1995	EST 8:00 A
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)					
218 74 5782		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	28 YRS.	MONTHS	DAYS	HOURS	MIN.	Aug. 5, 1966		Maryland			
9a. FACILITY NAME (If not institution, give street and number) 4801 Crowson Ave.										9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A	
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY <input checked="" type="checkbox"/> LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 4801 Crowson Ave.						10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) — Stock Boy		16b. KIND OF BUSINESS/INDUSTRY Grocery Store									
17. FATHER'S NAME (First, Middle, Last) Robert Allen Jones						18. MOTHER'S NAME (First, Middle, Maiden Surname) Peggy Ann Williams							
19a. INFORMANT'S NAME (Type/Print) Robert A. Jones						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2329 Hudson Dr., Salisbury, MD 21801							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify) —						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Mount Crematory		DATE 6/25/95	20c. LOCATION — City or Town, State Baltimore, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY CAFA Stephen D. Lohrmann, P.A. 8717 Green Pastures Dr., Baltimore MD 21286							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 8 months			
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Pseudomonas Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Acute and Fatal Cerebral Hemorrhage</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Sequelae of Traumatic Injury</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF):</p>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Mycobacterium avium Infection</i> <i>Cysticercosis Retinitis</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) Residential care facility											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY		26c. INJURY AT WORK? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER DO6966		29d. DATE SIGNED (Month, Day, Year) 6/26/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)  Robert Kent MD 1001 McCutcheon ST BALTO. MD 21204													
31. DATE FILED (Month, Day, Year) JUN 27 1995		RECEIVED FBI - BALTIMORE											

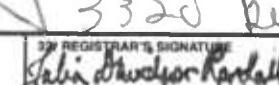


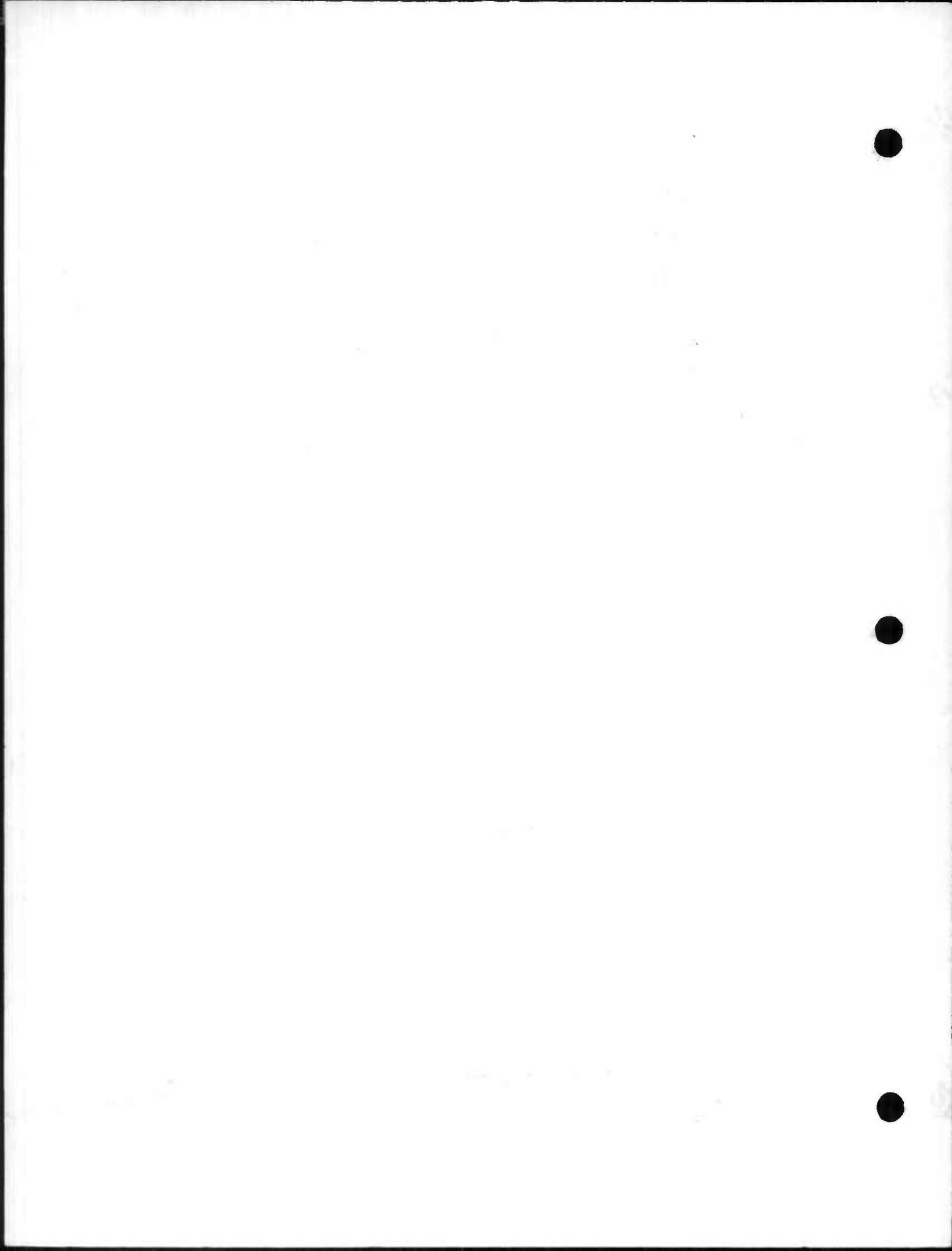
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or if item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR			2. DATE OF DEATH MONTH DAY YEAR							3. TIME OF DEATH	
1. DECEASED'S NAME (First, Middle, Last) Charles F. Joyce			7. DATE OF BIRTH (Month, Day, Year) APR 6 1906							8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD	
4. SOCIAL SECURITY NUMBER 217-09-4498			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 89 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
9a. FACILITY NAME (If not institution, give street and number) ST. ELIZABETH'S			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY							9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE MARYLAND			10b. COUNTY BALTIMORE Co.		10c. CITY, TOWN OR LOCATION BALTIMORE CATCHINGWELL MANOR			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1300 DORCHESTER AVE			10f. ZIP CODE 21207					10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MACHINIST			16b. KIND OF BUSINESS/INDUSTRY AIRCRAFT MANUFACTURE					
17. FATHER'S NAME (First, Middle, Last) CHARLES F. JOYCE			18. MOTHER'S NAME (First, Middle, Maiden Surname) HENRIETTA E. FISH								
19a. INFORMANT'S NAME (Type/Print) ETHEL WHITE			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1127 ELM RD., ARBUTUS, MD 21227								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY 6/23/95			DATE			20c. LOCATION — City or Town, State BALTIMORE, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY AMBROSIE FUNERAL HOME ARBUTUS, MD 1328 SULPHUR SPRING RD., 21227								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											Approximate Interval Between Onset and Death 14 days 5-7 hrs
<p>e. Cerebrovascular Accident DUE TO (OR AS A CONSEQUENCE OF): Cerebrovascular Disease</p> <p>b. Unknown DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. Unknown DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. Unknown</p>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 									29d. DATE SIGNED (Month, Day, Year) 6/27/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Healy											
31. DATE FILED (Month, Day, Year) JUN 27 1995			32. REGISTRAR'S SIGNATURE 								



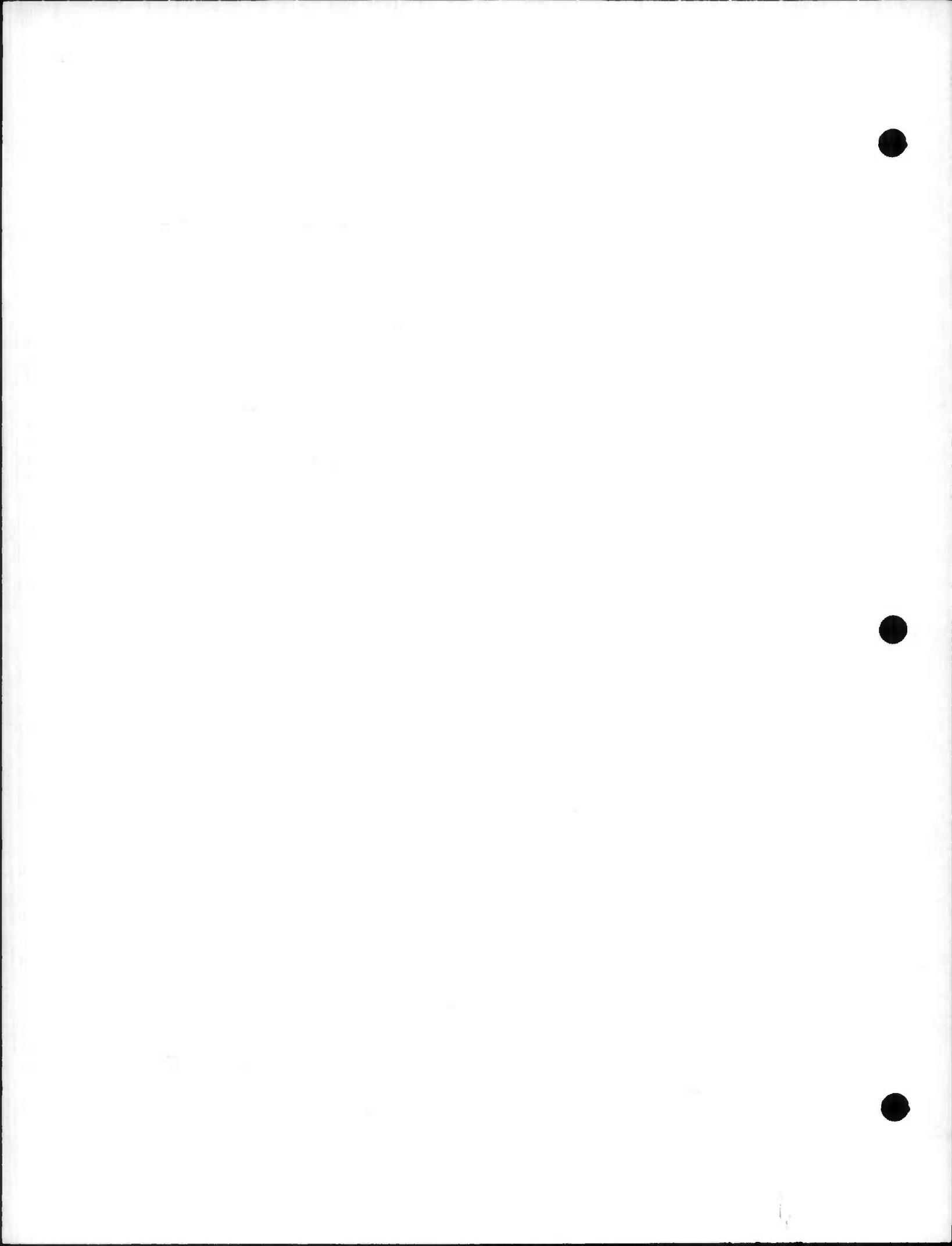
95 19367

1 - FOR
STATE
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

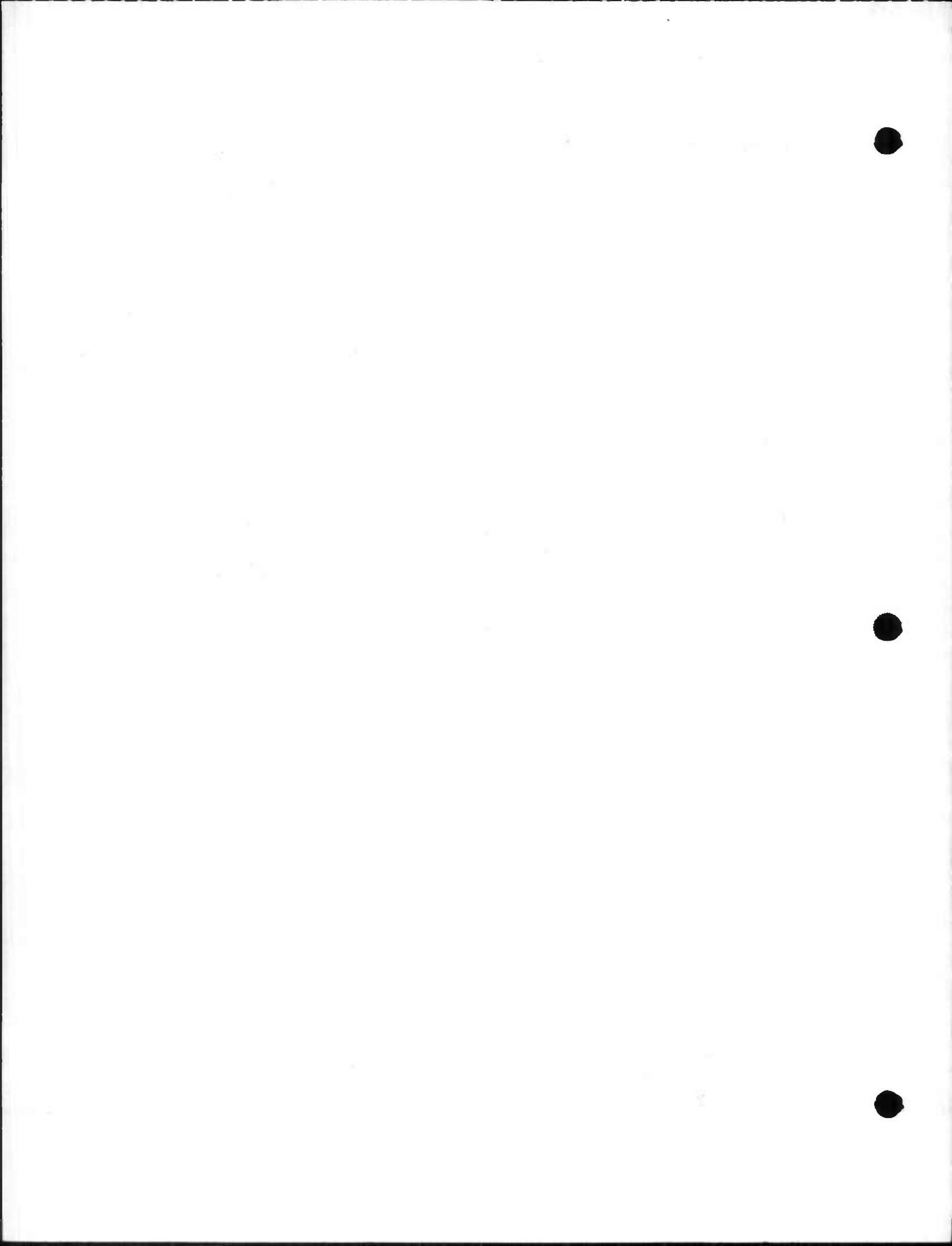
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Jones Patricia				2. DATE OF DEATH MONTH DAY YEAR 06-02-95	3. TIME OF DEATH 2:39 PM	
4. SOCIAL SECURITY NUMBER 240 88 5308		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) 7 5 1951	8. BIRTHPLACE (State or Foreign Country) North Carolina
9a. FACILITY NAME (If not institution, give street and number) Hyattsville Manor Health Care				9b. CITY, TOWN OR LOCATION OF DEATH Hyattsville		9c. COUNTY OF DEATH Piggy Md.
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION Hyattsville		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 4006 South Capital St., Wash. DC 20032			10f. ZIP CODE 20032		10g. CITIZEN OF WHAT COUNTRY? U.S.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary 10-12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) House Keeper			16b. KIND OF BUSINESS/INDUSTRY House Keeping
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gwendolyn Lewis		
19a. INFORMANT'S NAME (Type/Print) Gwendolyn Lewis			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 831 Bunch Drive Goldsboro N.C. 27530			20c. LOCATION — City or Town, State North Carolina
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Irvin Cannon Funeral Home			DATE 6-29
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dawn				22. NAME AND ADDRESS OF FACILITY 1712 W. North Avenue		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acquired immune deficiency syndrome DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death anm						
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. past smoking medical history				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 4-15-95		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED falling down
29e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify) at home		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) College Park, MD				
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29f. SIGNATURE AND TITLE OF CERTIFIER Louis Dennis				29g. LICENSE NUMBER 001499		29h. DATE SIGNED (Month, Day, Year) June 21, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Louis Dennis 6201 Greenbelt Rd., College Park, MD 20740-2356						
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Jane Dennis				



1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.
						2. DATE OF DEATH MONTH JUNE DAY 22, 1995 YEAR	3. TIME OF DEATH 1:30 P.M.	
1. DECEDENT'S NAME (First, Middle, Last) JONES, THEODORE		Theodore Jones				7. DATE OF BIRTH (Month, Day, Year) 5-18-53		8. BIRTHPLACE (State or Foreign Country) Md
4. SOCIAL SECURITY NUMBER 219-72-6799		5. SEX XXM 2 F	6. AGE (In yrs. last birthday) 42 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		
9a. FACILITY NAME (If not institution, give street and number) Fort Howard Hosp		9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD				9c. COUNTY OF DEATH Baltimore		
RESIDENCE OF DECEDENT								
10a. STATE Md	10b. COUNTY N.A.	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS YES 2 NO		
10e. STREET AND NUMBER 409 E. 28th St			10f. ZIP CODE 21218			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 6/26/79 - 6/25/82			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Black			14. RACE — American Indian, Black, White, etc. Specify: Black
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer			16b. KIND OF BUSINESS/INDUSTRY Housing Authority		
17. FATHER'S NAME (First, Middle, Last) Theodore JONES SR			18. MOTHER'S NAME (First, Middle, Maiden Surname) BETTIE WALKER					
19a. INFORMANT'S NAME (Type/Print) Bethie Jordan			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 409 E. 28th St Baltimore Md 21218					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hannan Forest Cem., 6/23 Orange Mills Md			DATE 6/23	20c. LOCATION — City or Town, State Orange Mills Md	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locks Jr			22. NAME AND ADDRESS OF FACILITY Locks Funeral Home 1304 N. Central St					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →								
a. END STAGE ACQUIRED IMMUNE DEFICIENCY DISEASE SYNDROME DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								
Approximate Interval Between Onset and Death 10 years								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER Aurora C. Tan, M.D.			29c. LICENSE NUMBER D14958			29d. DATE SIGNED (Month, Day, Year) ► 6/22/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) AURORA TAN, M.D., VAMC 9600 NORTH POINT ROAD, FORT HOWARD, MD 21052								
31. DATE FILED (Month, Day, Year) JUN 2 1995			32. REGISTRAR'S SIGNATURE Jahn Dawson-Randall					

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 6 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



95 19369

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

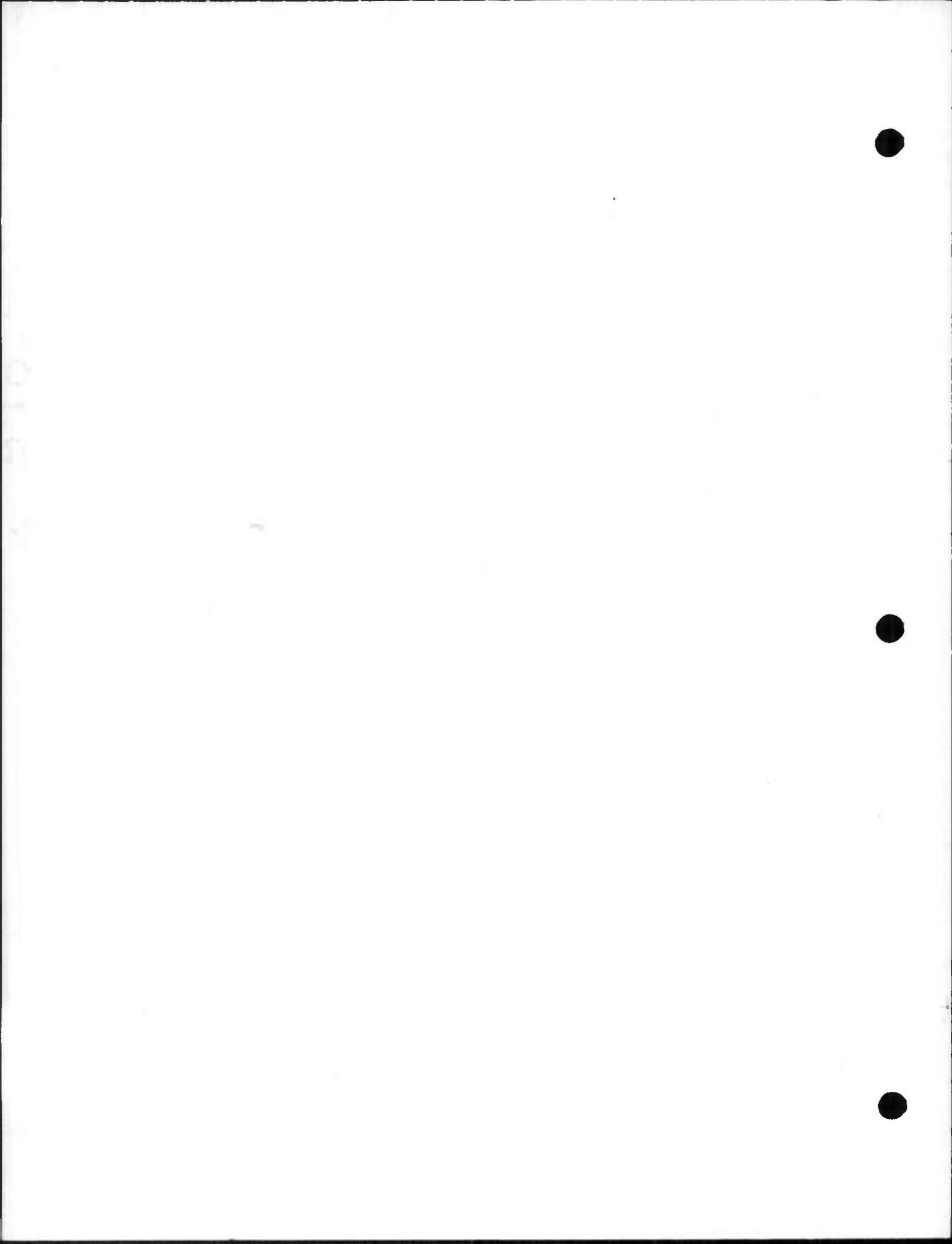
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 26 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 8:05 A M
LEE OTIS JAY, SR.											June 23, 1995	
4. SOCIAL SECURITY NUMBER 237-22-6028		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year) MAY 29, 1920	8. BIRTHPLACE (State or Foreign Country) N. Carolina	
9a. FACILITY NAME (If not institution, give street and number) 4809 Alhambra Avenue											9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	9c. COUNTY OF DEATH N/A
RESIDENCE OF DECEASED												
10a. STATE Maryland	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 4809 Alhambra Avenue										10f. ZIP CODE 21212	10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 9-23-42 - 1-5-46				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Tool Room Helper				16b. KIND OF BUSINESS/INDUSTRY Steel						
17. FATHER'S NAME (First, Middle, Last) Tommie Jay										18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Jordan		
19a. INFORMANT'S NAME (Type/Print) Enid Jay										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4809 Alhambra Ave./Baltimore, MD 21212		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Old Mt. Zion Bap. Ch. Cem. 6/27				20c. LOCATION — City or Town, State N. Carolina						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>S. Valencia Stollard</i>										22. NAME AND ADDRESS OF FACILITY March Funeral Home East 1101 E. North Avenue/Baltimore, MD 21202		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate interval Between Onset and Death		
a. _____ DUE TO (OR AS A CONSEQUENCE OF): <i>Severe Emphysema.</i>												
b. _____ DUE TO (OR AS A CONSEQUENCE OF):												
c. _____ DUE TO (OR AS A CONSEQUENCE OF):												
d. _____												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>HTN</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>										24c. LOCATION (Street and Number or Rural Route Number, City or Town, State) 52826	24d. DATE SIGNED (Month, Day, Year) ► 6/26/95	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>O. Valencia Stollard</i>										29c. LICENSE NUMBER 52826	29d. DATE SIGNED (Month, Day, Year) ► 6/26/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Aye Lewis MD 5010 YORK RD, BALTO, MD 21212												
31. DATE FILED (Month, Day, Year) 6.26.95		32. REGISTRAR'S SIGNATURE JUN 27 1995 <i>Jahn Stollard</i>										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

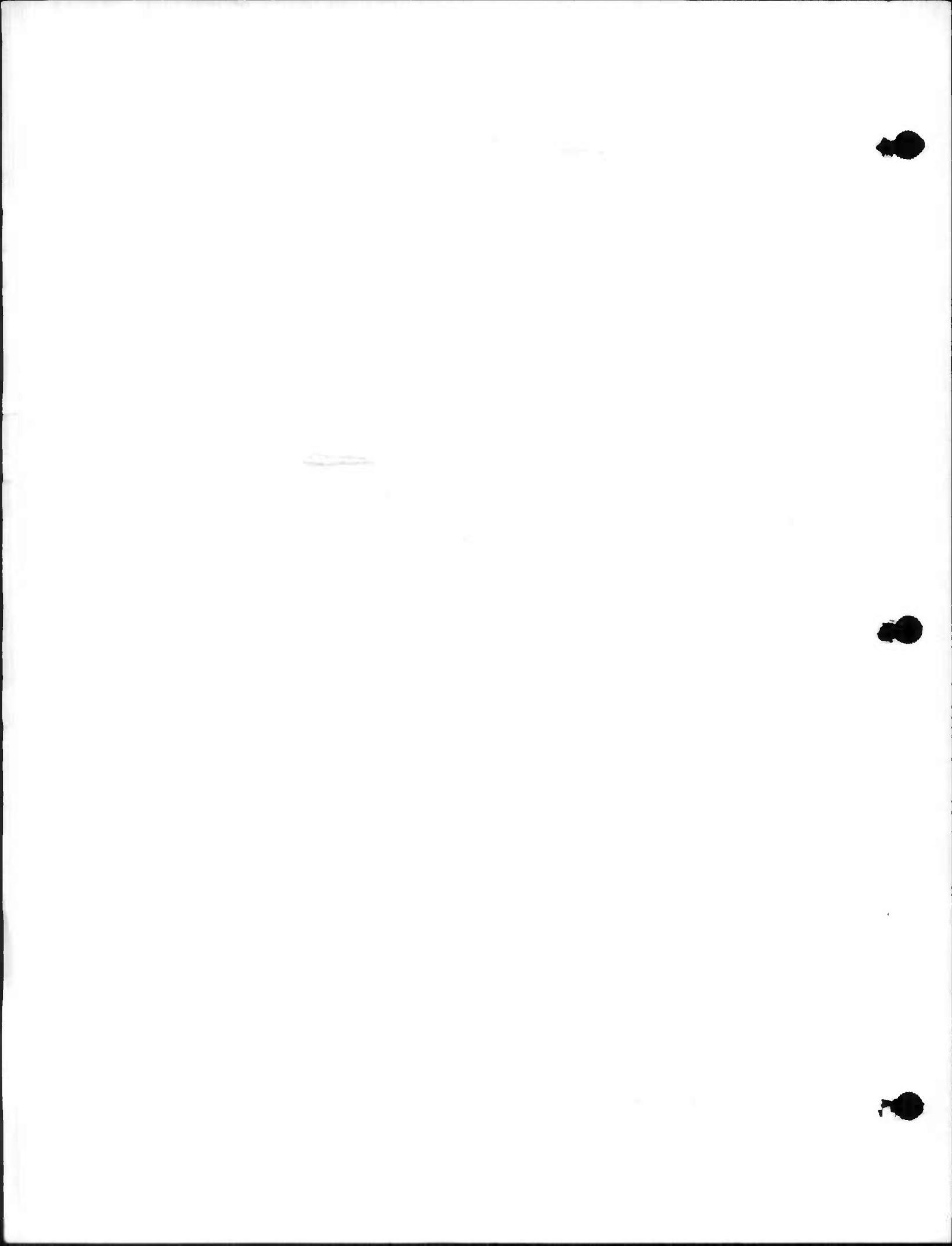
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 95 19370	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH JUNE DAY 23 YEAR 1995								3. TIME OF DEATH - 2:10 PM	
1. DECEDENT'S NAME (First, Middle, Last) SAMUEL HYATT										7. DATE OF BIRTH (Month, Day, Year) NOV. 13, 1906	8. BIRTHPLACE (State or Foreign Country) MD
4. SOCIAL SECURITY NUMBER 212-18-2048		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number) LEVINDALE										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	9c. COUNTY OF DEATH N/A
10e. STATE MD		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION OWINGS MILLS						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 35 F TAHOE CIRCLE										10f. ZIP CODE 21117	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) MASTER ELECTRICIAN				16b. KIND OF BUSINESS/INDUSTRY ELECTRICAL			
17. FATHER'S NAME (First, Middle, Last) LEWIS HYATT										16. MOTHER'S NAME (First, Middle, Maiden Surname) ROSLIE Blanche PERILOK	
19e. INFORMANT'S NAME (Type/Print) ROSLIE HYATT					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 35 F TAHOE CIRCLE, OWINGS MILLS, MD 21117						
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) ARLINGTON-CHIZUK AMUNO				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) 6-25-95				20c. LOCATION — City or Town, State BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sydney L. Stellman					22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):											
b. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HISTORY OF CONGESTIVE HEART FAILURE SICK SINUS SYNDROME										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER ATTENDING PHYSICIAN								29c. LICENSE NUMBER D 25610	29d. DATE SIGNED (Month, Day, Year) ► 6-23-95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) LEVINDALE 2434 W. BELVEDERE AVENUE BALTIMORE MD 21215											
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Julia Dawson-Hardell								DHMH-16 Rev 1/89	

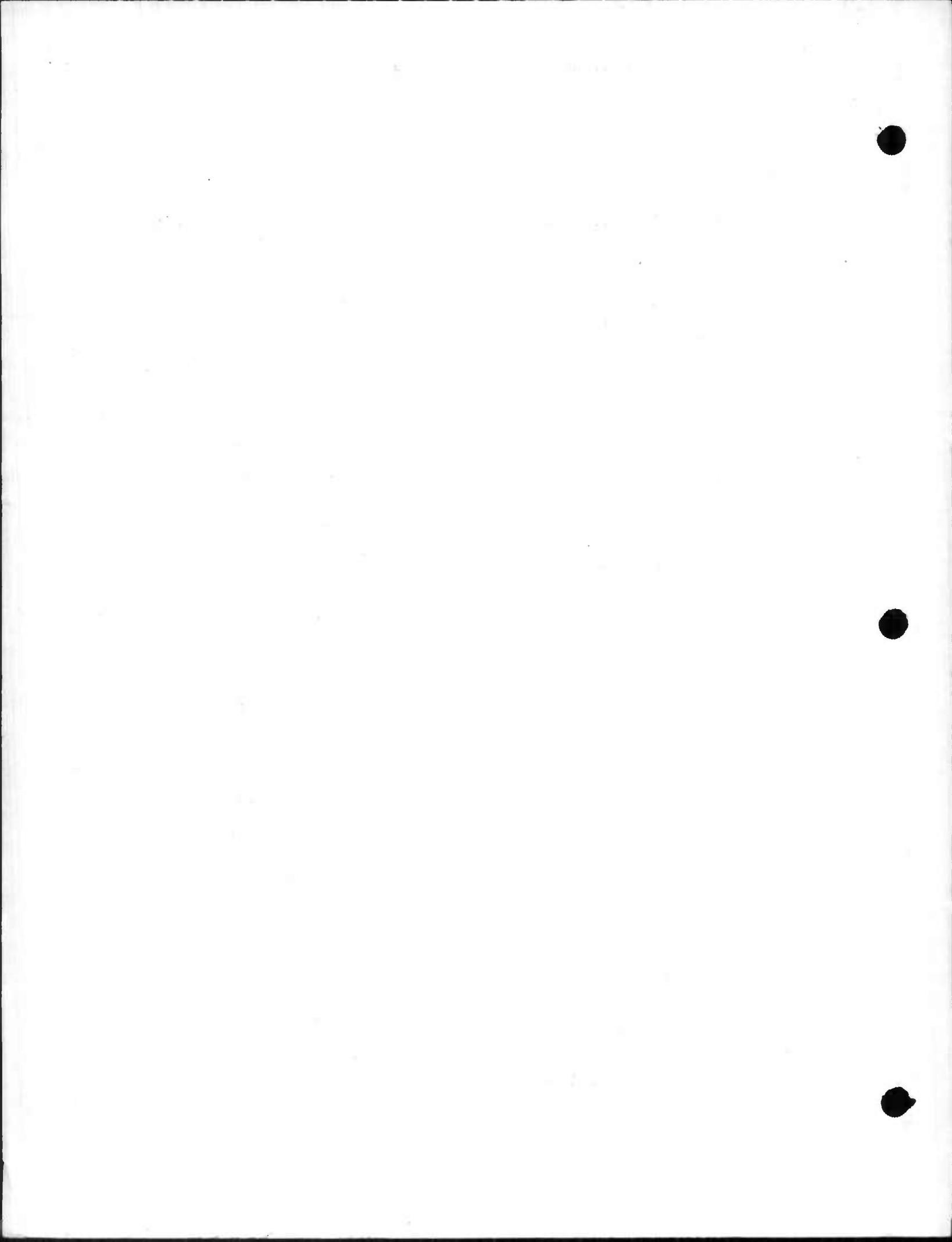


FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		JENETTA E HOWARD				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 02:47 A.M.	
4. SOCIAL SECURITY NUMBER 413-67-6793		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 46 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 6, 1949	
9a. FACILITY NAME (If not institution, give street and number) HOWARD CO. GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH Columbia				9c. COUNTY OF DEATH HOWARD			
10a. STATE Maryland		10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Columbia				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6890 Garland Lane		10f. ZIP CODE 21045				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 12		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 5+ Counselor		16b. KIND OF BUSINESS/INDUSTRY High School					
17. FATHER'S NAME (First, Middle, Last) Robert East		18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Montgomery							
19a. INFORMANT'S NAME (Type/Print) Robert G. Howard		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6890 Garland Lane Columbia, Maryland 21045							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. Cem.		June 27, 1995		20c. LOCATION — City or Town, State Owings Mills, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Homes 1630 Edmondson Avenue Catonsville, Maryland 21228							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF):									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER OCME				29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sharon Locke, MD 111 Penn Street, Baltimore, Maryland 21201									
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE 							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

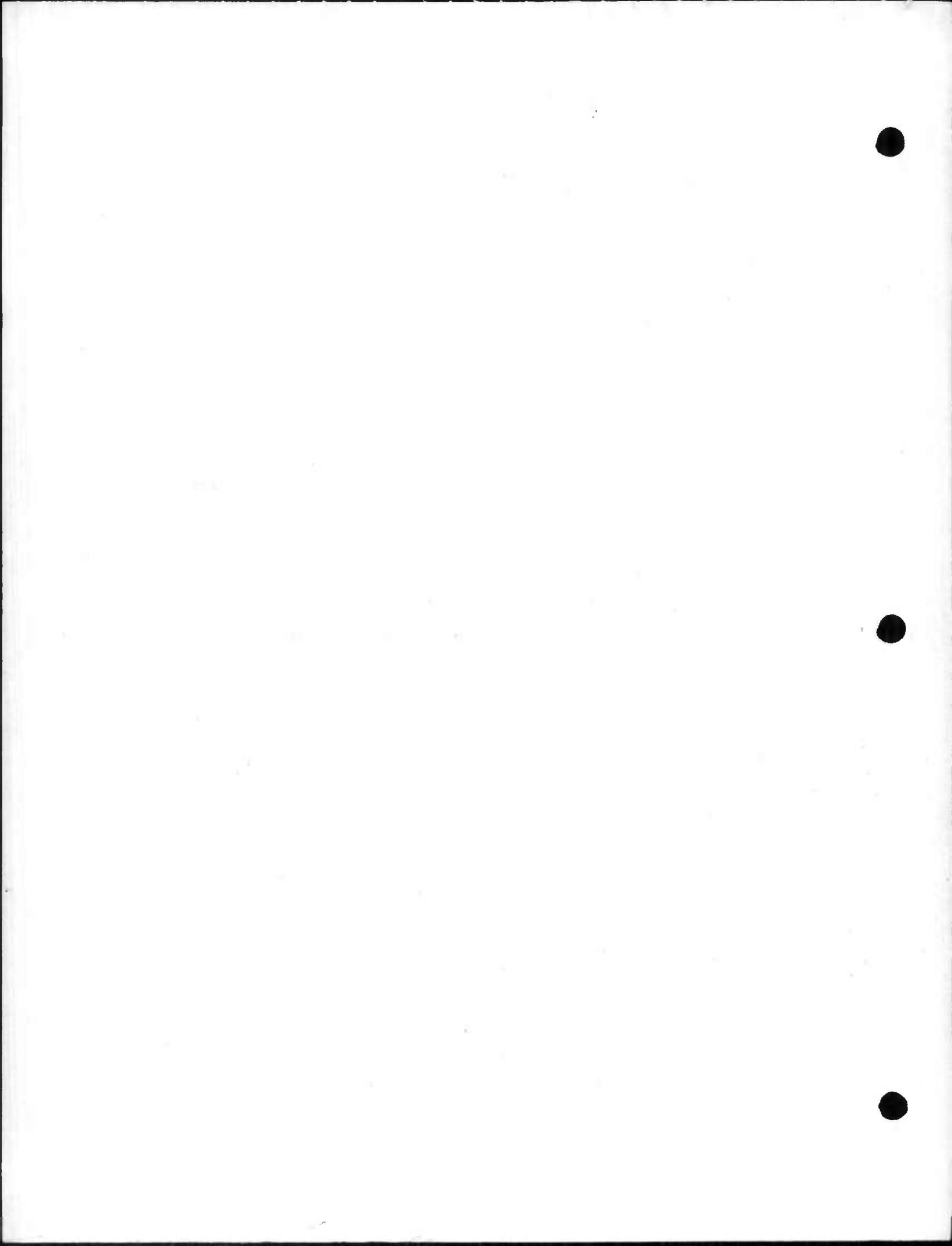
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 26 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 26 1995								3. TIME OF DEATH 2:45 A.M.	
1. DECEASED'S NAME (First, Middle, Last)		7. DATE OF BIRTH (Month, Day, Year) Sept. 19, 1917								8. BIRTHPLACE (State or Foreign (Country)) Maryland	
Dorothy D. Hope		9. FACILITY NAME (If not institution, give street and number) 6001 Foxhall Farm Road								9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEASED											
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Catonsville								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6001 Foxhall Farm Road		10f. ZIP CODE 21228								10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse			16b. KIND OF BUSINESS/INDUSTRY Health Care						
17. FATHER'S NAME (First, Middle, Last) David Danforth		18. MOTHER'S NAME (First, Middle, Maiden Surname) Margaret Oliphant									
19a. INFORMANT'S NAME (Type/Print) Daniel Hope Jr. (Spouse)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6001 Foxhall Farm Road Catonsville, Maryland 21228									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory				DATE June 26, 1995		20c. LOCATION — City or Town, State Catonsville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 6 mo	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Renal Cell Cancer</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month/Day/Year) ► 6/26/95	
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER S24356	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Wm C Watchfield MD St Agnes Hospital										30. REGISTERED SIGNATURE John Watchfield	
31. DATE FILED (Month, Day, Year) JUN 21 1995										OHMH-16 Rev 1/89	



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

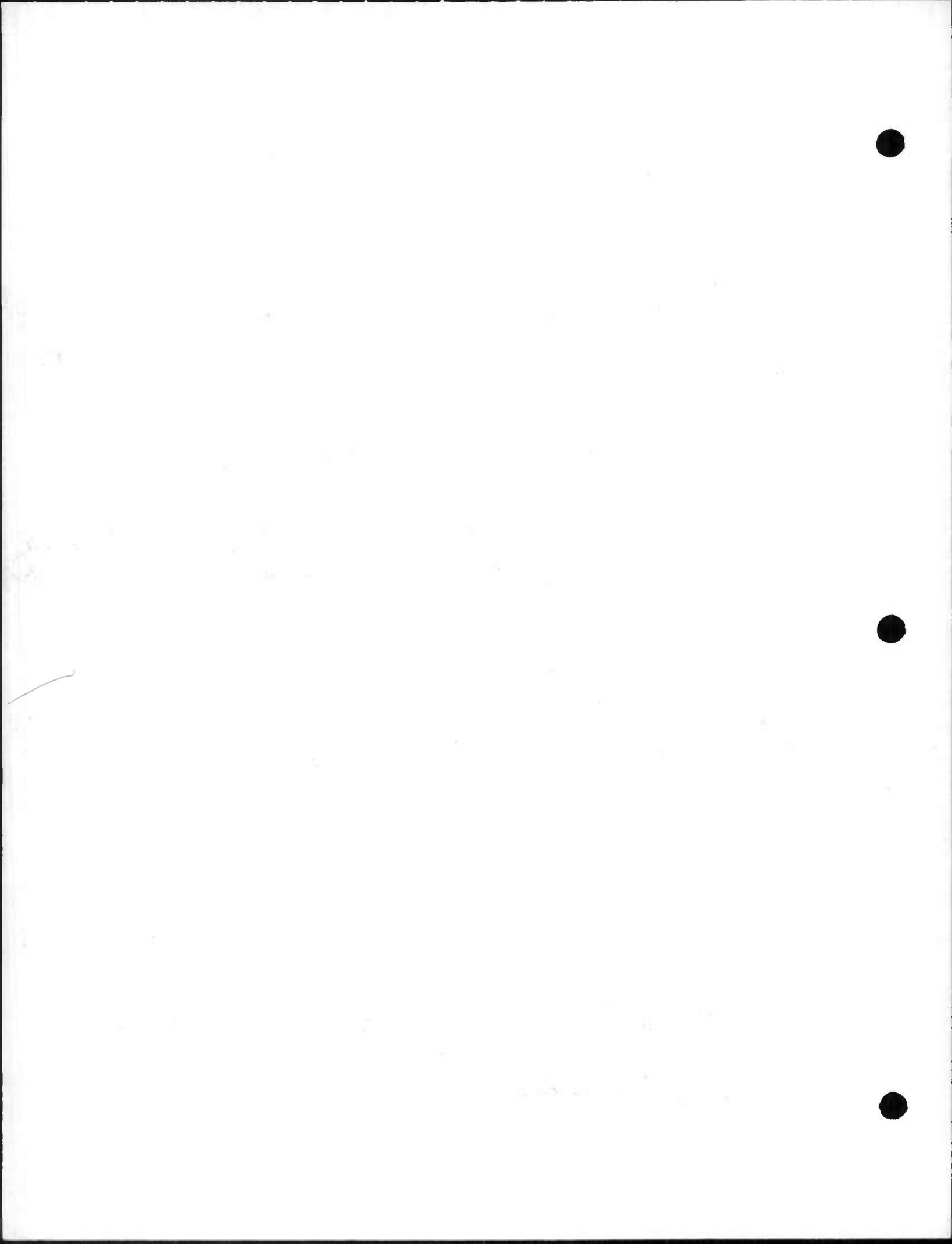
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19373

1. DECEDENT'S NAME (First, Middle, Last) Glenna HOPKINS				2. DATE OF DEATH MONTH DAY YEAR June 24, 1995	3. TIME OF DEATH 4:15 A.M.	
4. SOCIAL SECURITY NUMBER 220-24-1143				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE Hospital				7. DATE OF BIRTH (Month, Day, Year) APRIL 4, 1916		8. BIRTHPLACE (State or Foreign Country) OHIO
RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore Co.		9c. COUNTY OF DEATH Baltimore County
10a. STATE MD.	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 20 ARMOR CT				10f. ZIP CODE 21220	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) FRANCIS ARNOLD				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE JONES		
19a. INFORMANT'S NAME (Type/Print) WAYNE L Hopkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 ARMOR CT. BALTO. 21220 Md.		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) HOLLY HILLS CEM 6/28		DATE 6/28	20c. LOCATION — City or Town, State BALTO. Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Donald J. Noce II				22. NAME AND ADDRESS OF FACILITY DELLA NOCE + SONS FUNERAL HOME 322 S. HIGH ST. BALTO. 21202 Md.		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) →						
a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF):						
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						
b. Aspiration DUE TO (OR AS A CONSEQUENCE OF):						
c. Sepsis DUE TO (OR AS A CONSEQUENCE OF):						
d. Urinary Tract Infection						
Approximate Interval Between Onset and Death 12 hours						
4 days						
3 days						
3 days						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH X Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO M 1	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO NO	28d. DESCRIBE HOW INJURY OCCURED N/A
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A				
29b. SIGNATURE AND TITLE OF CERTIFIER Eliot Battle, MD				29c. LICENSE NUMBER RD 1760		29d. DATE SIGNED (Month, Day, Year) ► 6/24/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Eliot Battle, MD 9000 Franklin Square Drive Baltimore, MD 21237						
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Jean Shuler Harrell				

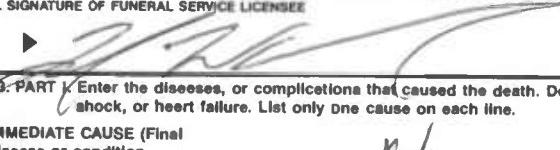
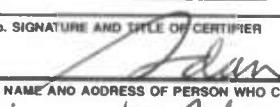


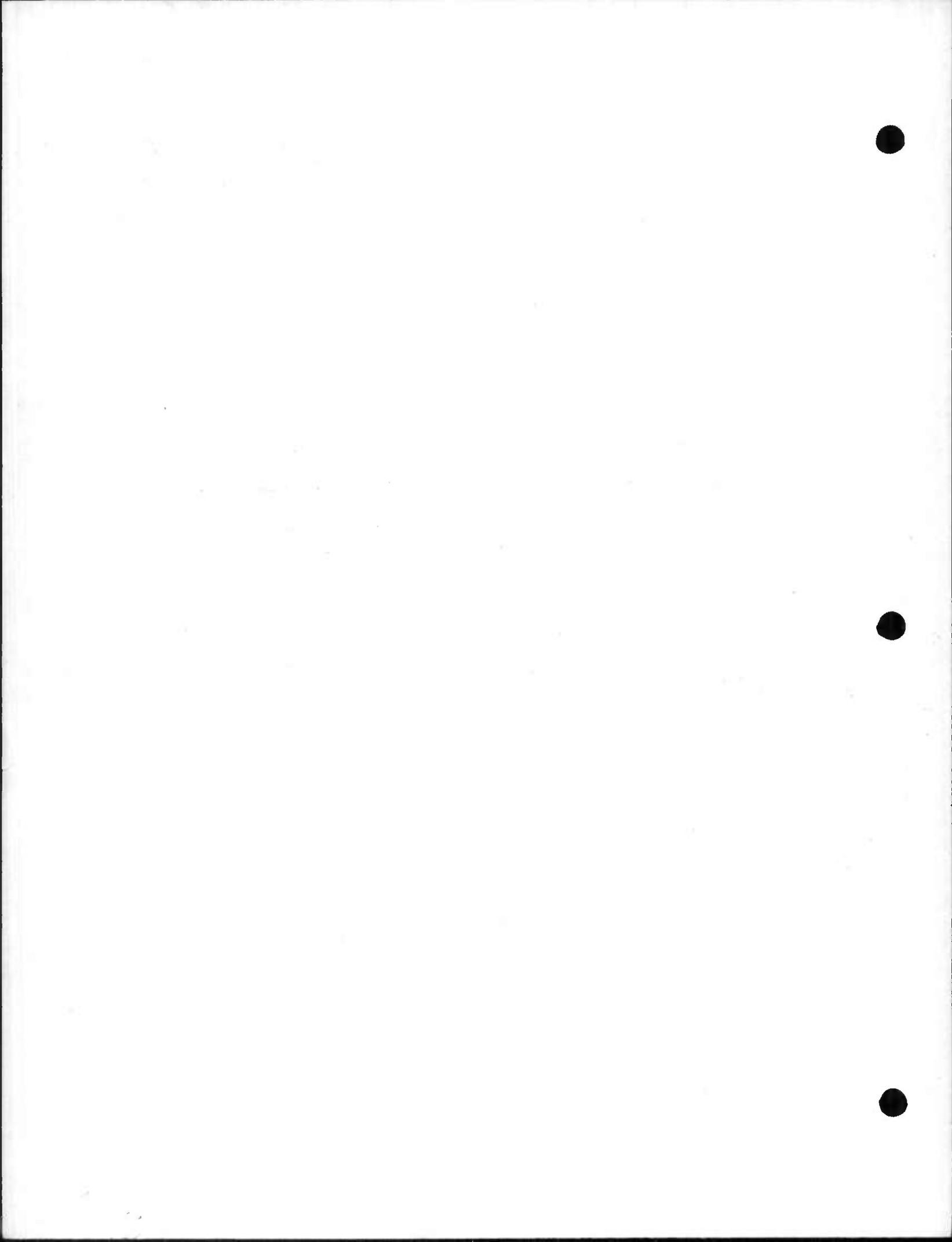
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial/cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Erline Zinck LaMont										June 25 1995	3:25 A.M.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
213-40-0010		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	93 YRS.	MONTHS	DAYS	HOURS	MIN.	12/04/01		Nova Scotia	
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	
Manor Care Towson										Towson	
RESIDENCE OF DECEDENT										9c. COUNTY OF DEATH	
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
MD				Baltimore City						<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
1311 D East Belvedere Avenue										21239	U.S.A.
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
<input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12)		College (1-4 or 5+) 4 nurse				hospital					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
John H. Zinck										Rosina D. Lohnes	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Elizabeth H. Murkey										2500 Garsden Ct.; Phoenix, MD 21131	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
		Woodlawn Cemetery				6/27		Woodlawn, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd.; Towson, MD 21286	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										30 min.	
a. <i>Pulmonary edema - presumptive</i>										2 years.	
b. <i>Third degree flutter</i>											
c. <i>Due to (or as a consequence of):</i>											
d. <i>Due to (or as a consequence of):</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Massive cardiomegaly (VS 4 months ago)</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER	29d. DATE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joseph Adams MD 7401 Osler Drive Towson 21207</i>										D32783	6/26/95
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE <i>John Andrew Kordell</i>									



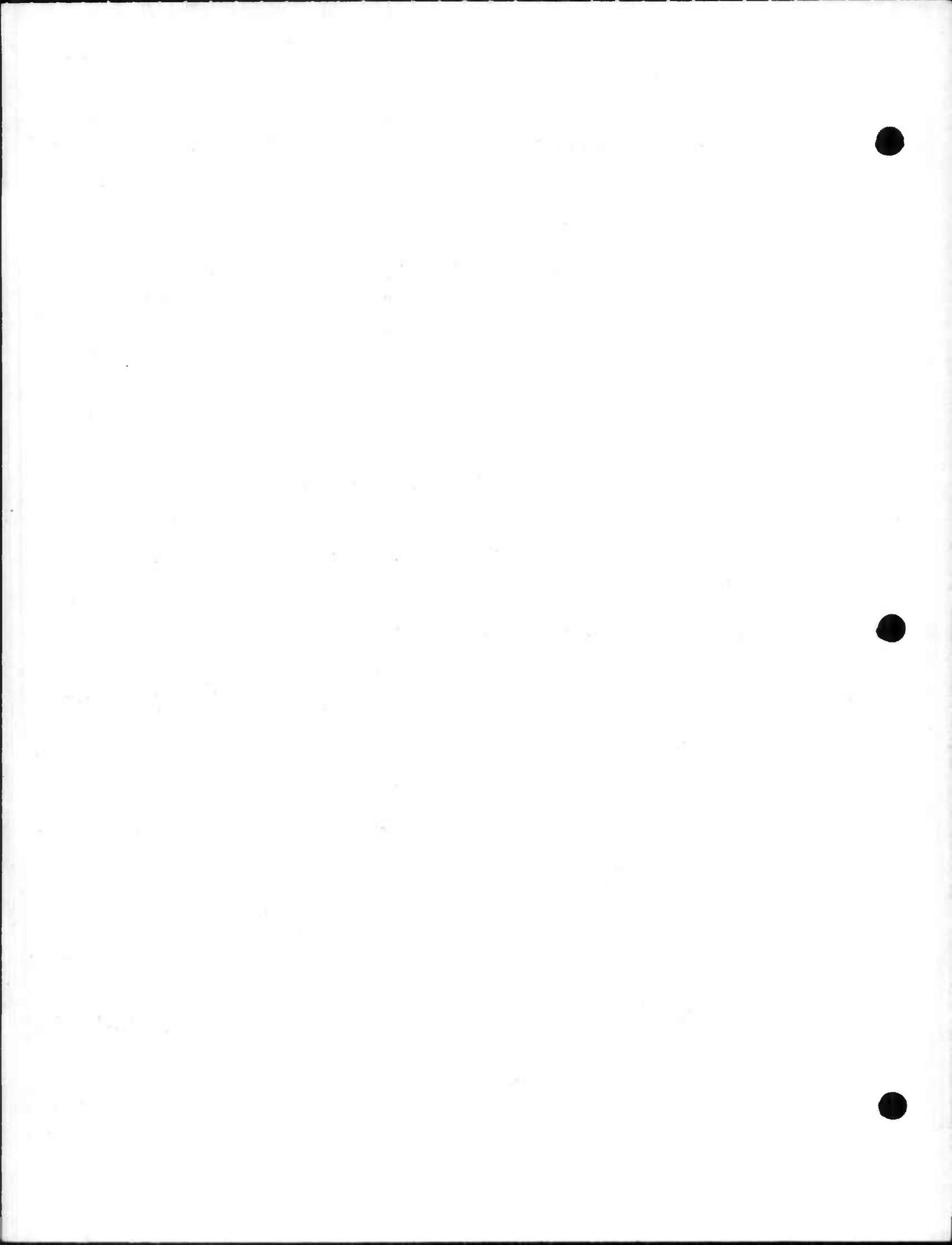
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		Charles A. Lundgren								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 140-09-0341		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 84 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 18, 1910		8. BIRTHPLACE (State or Foreign Country) Howard	
9a. FACILITY NAME (If not institution, give street and number) Howard County General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Columbia								9c. COUNTY OF DEATH Howard	
RESIDENCE OF DECEDENT											
10a. STATE MD	10b. COUNTY Howard	10c. CITY, TOWN OR LOCATION Columbia								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 6336 Cedar Lane		10f. ZIP CODE 21044								10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Accountant				16b. KIND OF BUSINESS/INDUSTRY General Motors Corp.					
17. FATHER'S NAME (First, Middle, Last) Arnold Lundgren		18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Loop									
19a. INFORMANT'S NAME (Type/Print) Donald Lundgren (Son)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9462 Single Bird Lane, Columbia, MD 21046									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Metro Crematory		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) June 26, 1995				DATE		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell Witzke</i>		22. NAME AND ADDRESS OF FACILITY Leroy & Russell Witzke Funeral Home 5555 Twin Knolls Rd. Columbia, MD 21045									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. <u>Colon carcinoma</u> DUE TO (OR AS A CONSEQUENCE OF):											
b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):											
c. <u>Cerebrovascular Accident</u> DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerry I. Levine, MD</i>		29c. LICENSE NUMBER 022856				29d. DATE SIGNED (Month, Day, Year) June 24, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerry I. Levine, MD 11055 Little Patuxent Pkwy, Columbia, MD 21028											
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE <i>Jeanne D'Amico-Hardell</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

Item 5 7-27-95 FilmG725 W.H.Per F/H

95 19376

1. FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Eileen Lee</i>				2. DATE OF DEATH MONTH DAY YEAR <i>June 21, 95</i>	3. TIME OF DEATH HRS. MIN. <i>10:15 A M</i>
4. SOCIAL SECURITY NUMBER <i>219-16-4126</i>		5. SEX <i>M</i>	6. AGE (In yrs. last birthday) 70 YRS.	IF UNDER 1 YEAR MONTHS DAYS <i>0 0</i>	IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>
9a. FACILITY NAME (If not institution, give street and number) NORTHWEST HOSPITAL CENTER RESIDENCE OF DECEASED				9b. CITY, TOWN OR LOCATION OF DEATH RANDALLSTOWN	
10a. STATE <i>MARYLAND</i>	10b. COUNTY <i>BALTIMORE</i>	10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 16 OLD COURT RD., APT. 715				10f. ZIP CODE 21208	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>X</i>			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <i>White</i>	14. RACE — American Indian, Black, White, etc. Specify:
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) <i>BOOKKEEPER</i>			16b. KIND OF BUSINESS/INDUSTRY <i>OPTICAL</i>
17. FATHER'S NAME (First, Middle, Last) <i>BENJAMIN KUPPER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ROSE BROWN</i>	
19a. INFORMANT'S NAME (Type/Print) <i>MRS. EILEEN</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) ARO 26588 BASSWOOD AVE. RANCHO PALOS VERDES, CA 90275		
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i></i>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>CHIZUK AMUNO - ARLINGTON - 6-25-1995</i>		DATE <i>6-25-1995</i>	20c. LOCATION — City or Town, State <i>BALTIMORE, MD</i>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Buster H. Lewellen</i>			22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
<p>a. <i>Coronary artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i></i></p> <p>b. <i>status post myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): <i></i></p> <p>c. <i>Infective heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i></i></p> <p>d. <i>Inspiratory pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): <i></i></p>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ventricular obstructive pulmonary Disease</i>					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i></i>	28b. TIME OF INJURY M <i></i>	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <i></i>	28d. DESCRIBE HOW INJURY OCCURRED <i></i>
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i></i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i></i>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alice S. Hause</i>				29c. LICENSE NUMBER <i>H43974</i>	29d. DATE SIGNED (Month, Day, Year) <i>June 21, 95</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Hsieh, Alice Northwest Hospital, Randallstown, Md</i>					
31. DATE FILLED (Month, Day, Year) <i>JUN 27 1995</i>	REGISTRAR'S SIGNATURE <i>Jahn G. Schubert</i>				

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

X -

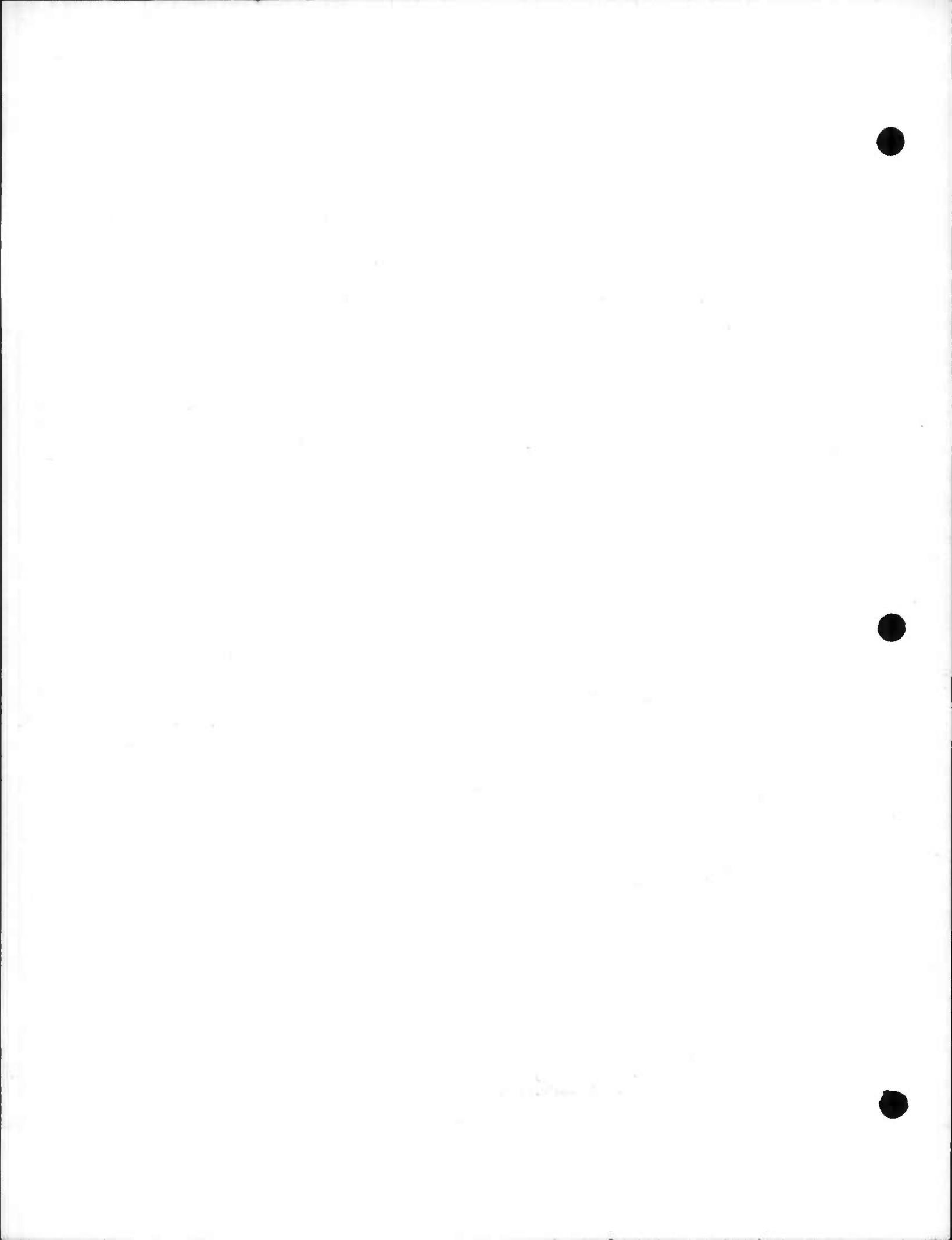
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		Harry E. Katz								2. DATE OF DEATH MONTH DAY YEAR June 21 95	3. TIME OF DEATH 3:25 PM		
4. SOCIAL SECURITY NUMBER 215-32-9600		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) DEC. 20, 1935		8. BIRTHPLACE (State or Foreign Country) NEW YORK			
9a. FACILITY NAME (If not institution, give street and number) GOOD SAMARITAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE								9c. COUNTY OF DEATH N/A			
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 2802 UPRIIDGE CT, APT. B		10f. ZIP CODE 21234								10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHAUFFEUR				16b. KIND OF BUSINESS/INDUSTRY TRANSPORTATION							
17. FATHER'S NAME (First, Middle, Last) BERT KATZ		18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH MACHLIS											
19a. INFORMANT'S NAME (Type/Print) MR. SIDNEY KATZ		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8 POMONA NORTH APT. 10 BALTIMORE, MD 21208											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SWINICHER WOLINER BENEVOLENT SOCIETY				DATE		20c. LOCATION — City or Town, State 6-23-95 BALTO., MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 3 months	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Renal Cell Carcinoma, metastatic DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dilated cardiomyopathy.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER M.D.		29c. LICENSE NUMBER D 47423				29d. DATE SIGNED (Month, Day, Year) ► June, 21, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ali M. Saifi, 5601 Loch Raven Blvd, Baltimore, MD 21239													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 											



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

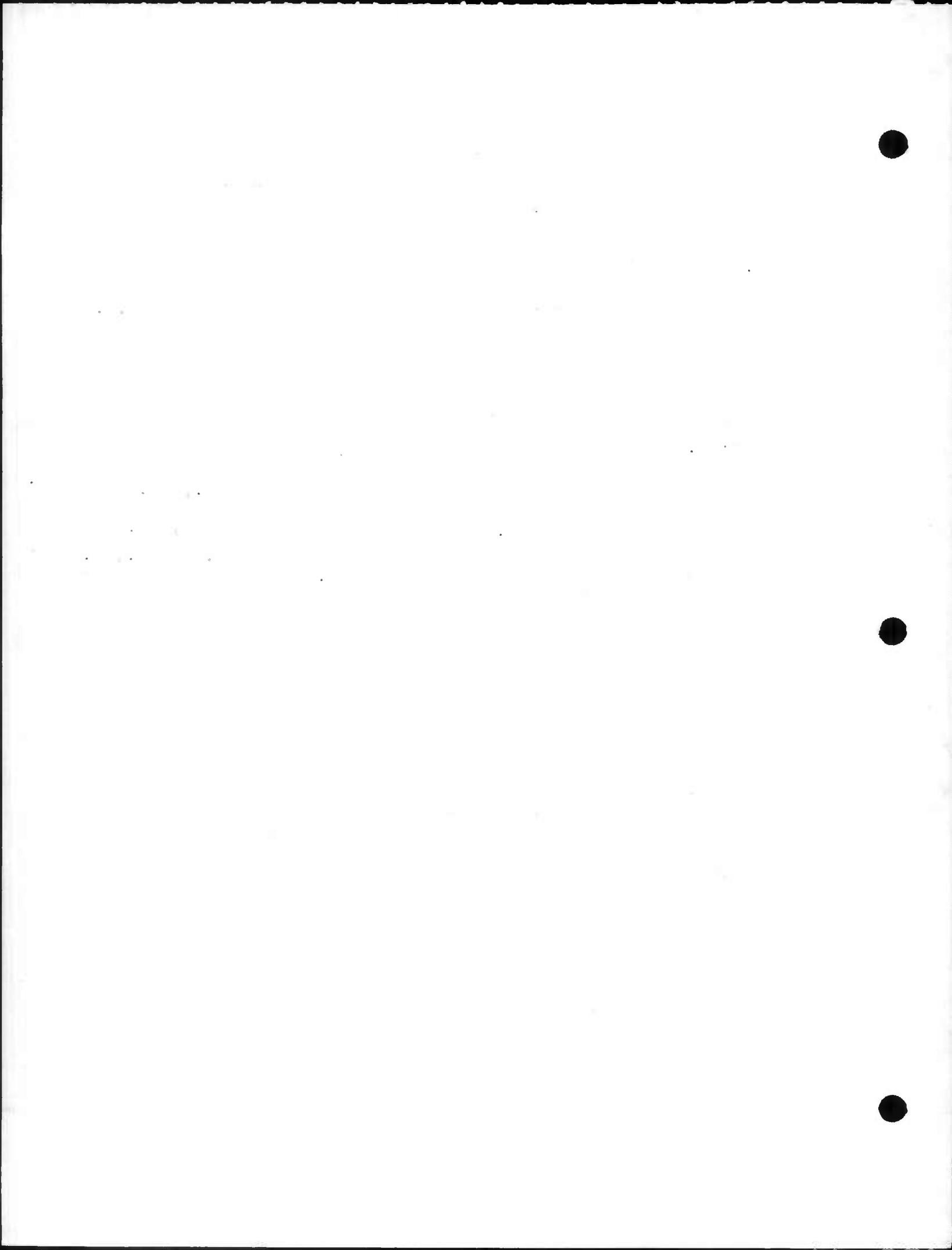
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 22 1995								3. TIME OF DEATH 4:45 PM	
1. DECEDENT'S NAME (First, Middle, Last) Florence E. Kelson										7. DATE OF BIRTH (Month, Day, Year) 04-09-1900	8. BIRTHPLACE (State or Foreign Country) Maryland
4. SOCIAL SECURITY NUMBER 212-36-3989		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 95 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.						
9a. FACILITY NAME (If not institution, give street and number) Deaton Specialty Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	9c. COUNTY OF DEATH N/A
10e. STATE MD.		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 611 South Charles Street										10f. ZIP CODE 21230	10g. CITIZEN OF WHAT COUNTRY? U.S.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0		16b. KIND OF BUSINESS/INDUSTRY Beautician		17. FATHER'S NAME (First, Middle, Last) Major P. Kelson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Gertrude Neal	
19a. INFORMANT'S NAME (Type/Print) Maude Dorsey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 McMechen Street Balto., MD. 21217 Apt 204							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or other place) MT. Auburn Cemetery		DATE 6/27		20c. LOCATION — City or Town, State Balto, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Vernon R. Bailey #M00014		22. NAME AND ADDRESS OF FACILITY 4216 Ridgewood Ave. Balto., MD. 21215		Vernon R. Bailey Funeral Service							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 14 Days	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Urosepsis		e. DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		{ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ATHEROSCLEROTIC CARDIOVASCULAR DISEASE, POLYPHERAL VASCULAR DISEASE, DEMENTIA, ANEMIA										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) M		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 		28f. LOCATION (Street and Number or Rural Route Number; City or Town, State) 									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Brian C. Wallace, MD								29c. LICENSE NUMBER D31136	29d. DATE SIGNED (Month, Day, Year) JUNE 23, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Brian C. Wallace, MD, 611 S. CHARLES ST., BALTIMORE, MD 21230										31. DATE FILED (Month, Day, Year) JUN 27 1995	
32. REGISTRAR'S SIGNATURE											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

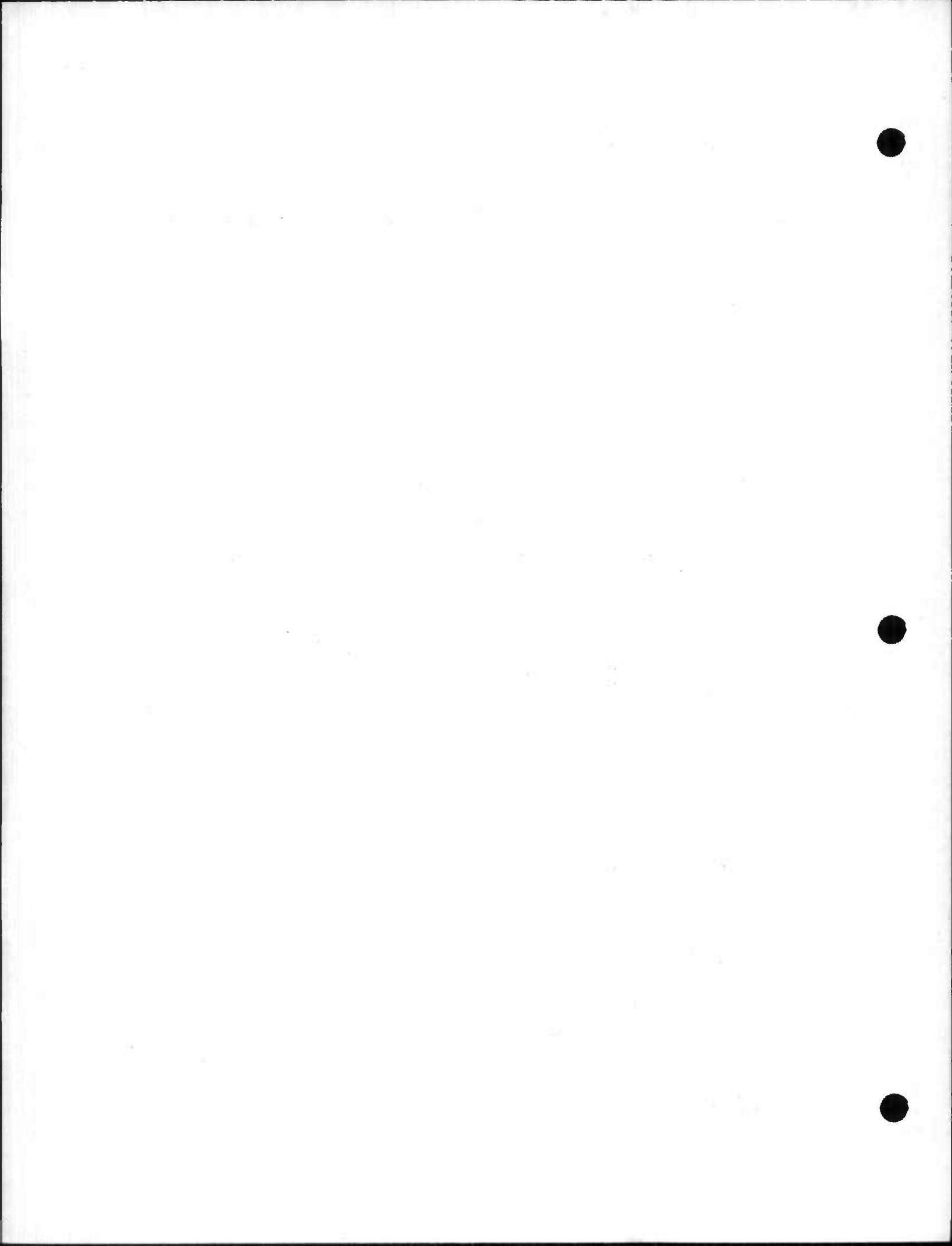
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19379

1. DECEDENT'S NAME (First, Middle, Last)		Michael Joseph Kocis				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 071 16 0101		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 03 26 15	8. BIRTHPLACE (State or Foreign Country) Pennsylvania
9a. FACILITY NAME (If not institution, give street and number) Harford Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace				9c. COUNTY OF DEATH Harford	
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Eastwood			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 7328 Stratton Way					10f. ZIP CODE 21224	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W. 2			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chauffeur			16b. KIND OF BUSINESS/INDUSTRY Trucking		
17. FATHER'S NAME (First, Middle, Last) Joseph Kocis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Furtunak			
19a. INFORMANT'S NAME (Type/Print) Helen M. Kocis				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7328 Stratton Way Balto., Md. 21224			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery		DATE 6-28-95	20c. LOCATION — City or Town, State Eastwood, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Charles S. Zeiler				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & DSon Inc. 6224 Eastern Avenue Balto., Md.			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. Cardio respiratory failure DUE TO (OR AS A CONSEQUENCE OF): b. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. LICENSE NUMBER D2066			
29d. DATE SIGNED (Month, Day, Year) ► 6/25/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. T. Lee MD 307 S. Union Ave				32. REGISTRAR'S SIGNATURE John W. Parker			
31. DATE FILED (Month, Day, Year) JUN 27 1995							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

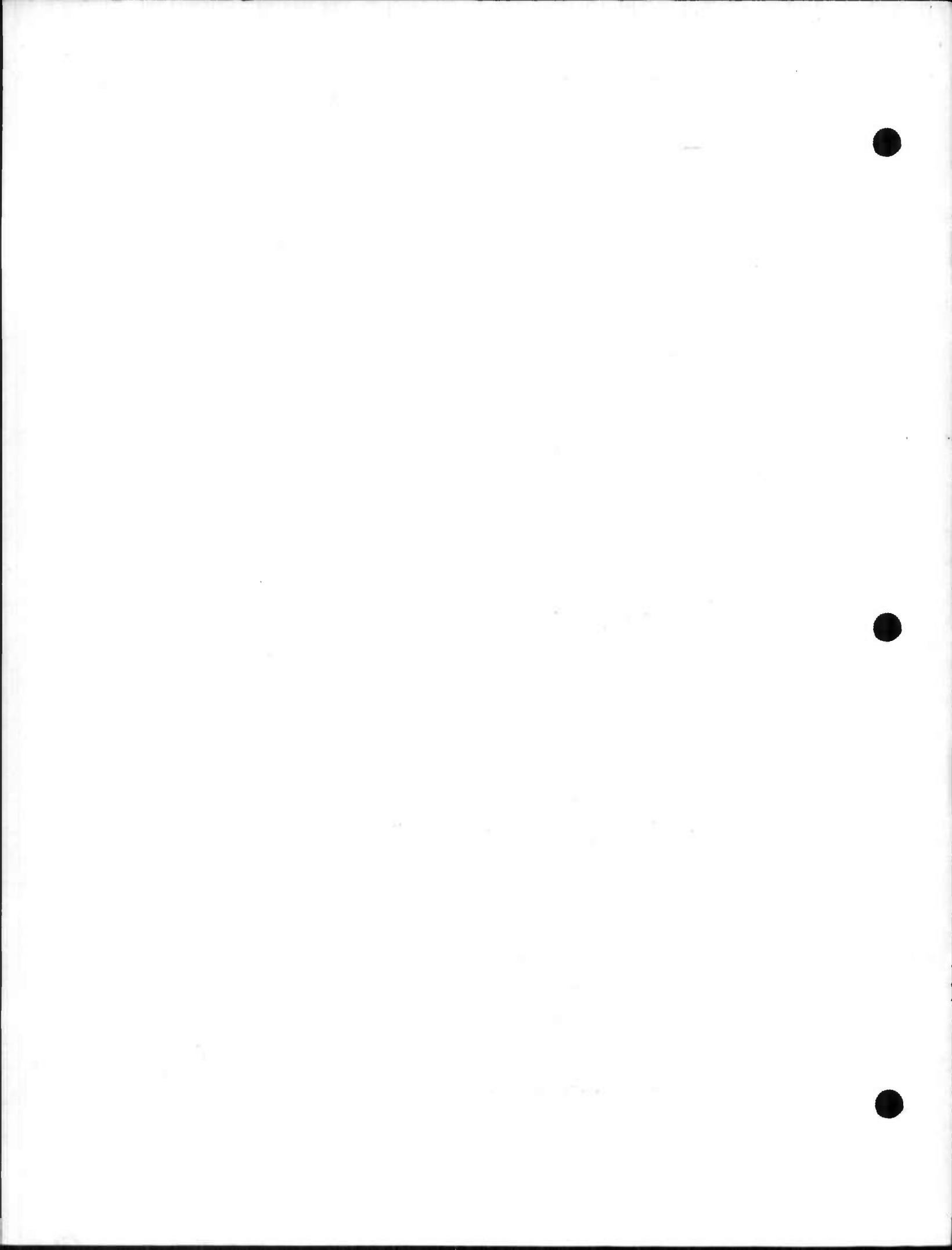
ITEM: 1. PER F.H. FILM G-724 6/27/95 t.t.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19380

1. DECEDENT'S NAME (First, Middle, Last) Helen M. Karasinski						2. DATE OF DEATH MONTH 06 DAY 25 YEAR 1995	3. TIME OF DEATH 4:15 pm M
4. SOCIAL SECURITY NUMBER 214-38-5946		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 8-19-1913	8. BIRTHPLACE (State or Foreign Country) Poland
9a. FACILITY NAME (If not institution, give street and number) St. Joseph's Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Catonsville		9c. COUNTY OF DEATH Baltimore	
10b. STATE MD.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville			
10e. STREET AND NUMBER 1222 Tugwell Drive				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Charwoman			16b. KIND OF BUSINESS/INDUSTRY Bank		
17. FATHER'S NAME (First, Middle, Last) Unknown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mazur			
19a. INFORMANT'S NAME (Type/Print) Irene Choinski				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Gusryan Street Balto., Md. 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Sacred Heart of Jesus Cemetery		DATE 6-27-95	20c. LOCATION — City or Town, State Dundalk, Md
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Charles S. Zeiler				22. NAME AND ADDRESS OF FACILITY Charles S. Zeiler & Son Inc. 6224 Eastern Avenue Balto., Md. 21224			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Possible Aspiration pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i></i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i></p>							
Approximate Interval Between Onset and Death 2 Days 2 weeks							
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
<p><i>Hypertension</i> <i>Diabetes Mellitus T</i></p> <p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/></p>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> ND			
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)		29b. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29a. CERTIFIER (Check only one)		29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29c. SIGNATURE AND TITLE OF CERTIFIER Edmund P. Tkacuk				29c. LICENSE NUMBER D34951		29d. DATE SIGNED (Month, Day, Year) ► 6-27-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edmund P. Tkacuk 405 Frederick Rd. Catonsville MD 21228							
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE John Michael Marshall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

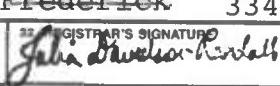
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

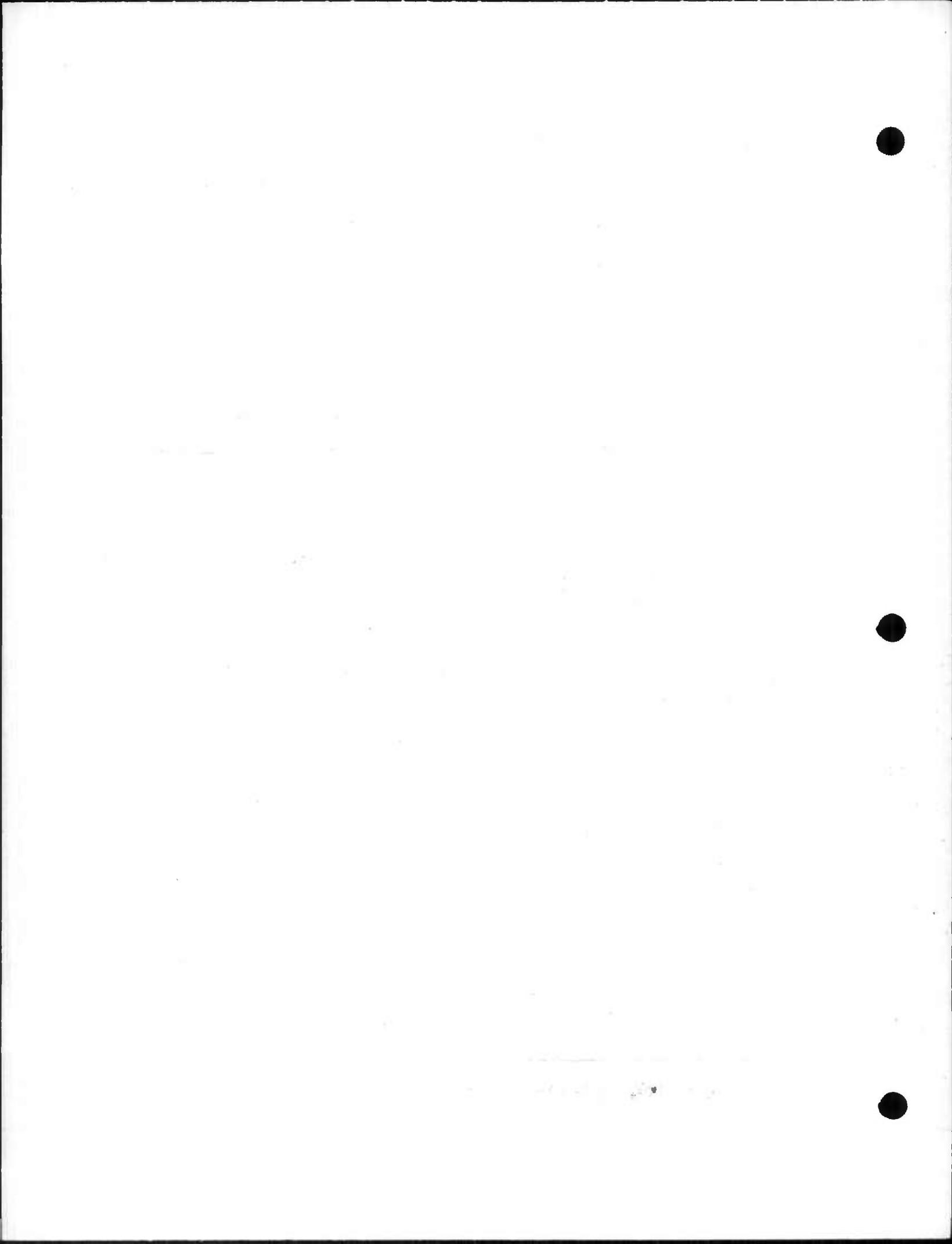
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) STELLA NESTER										2. DATE OF DEATH MONTH 6 DAY 20 YEAR 95	3. TIME OF DEATH 4:00 p m	
4. SOCIAL SECURITY NUMBER 226-32-3088		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 97 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) 2-14-1898	8. BIRTHPLACE (State or Foreign Country) Virginia					
9a. FACILITY NAME (If not institution, give street and number) 3800 Blenheim Rd.										9b. CITY, TOWN OR LOCATION OF DEATH Phoenix	9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEASED												
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Phoenix								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3800 Blenheim Rd.					10f. ZIP CODE 21131				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Homemaker			17. FATHER'S NAME (First, Middle, Last) Thomas Jefferson Mabry			18. MOTHER'S NAME (First, Middle, Maiden Surname) Artie Missie Warrell Worrell	
19a. INFORMANT'S NAME (Type/Print) Wanda Montgomery					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3800 Blenheim Rd. Phoenix, Md. 21131							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) X		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Dublin Presbyterian			DATE 6-24		20c. LOCATION — City or Town, State Dublin, Va					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate interval Between Onset and Death		
<p>b. <i>Atrial fibrillation with rapid ventricular response</i> 4 yrs <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i>Arteriosclerotic Cardiovascular Disease</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i>Hypertension</i> <small>DUE TO (OR AS A CONSEQUENCE OF):</small> <i></i> </p>										15 yrs 30 yrs		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 										
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER 	29c. LICENSE NUMBER 3223450	29d. DATE SIGNED (Month, Day, Year) ► 6/21/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. WALTER HEPNER Dr. Barbara Frederick										31. DATE FILED (Month, Day, Year) JUN 26 1995		
										32. REGISTRAR'S SIGNATURE 		



DIVISION OF VITAL RECORDS, P.O. BOX 68760

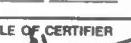
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

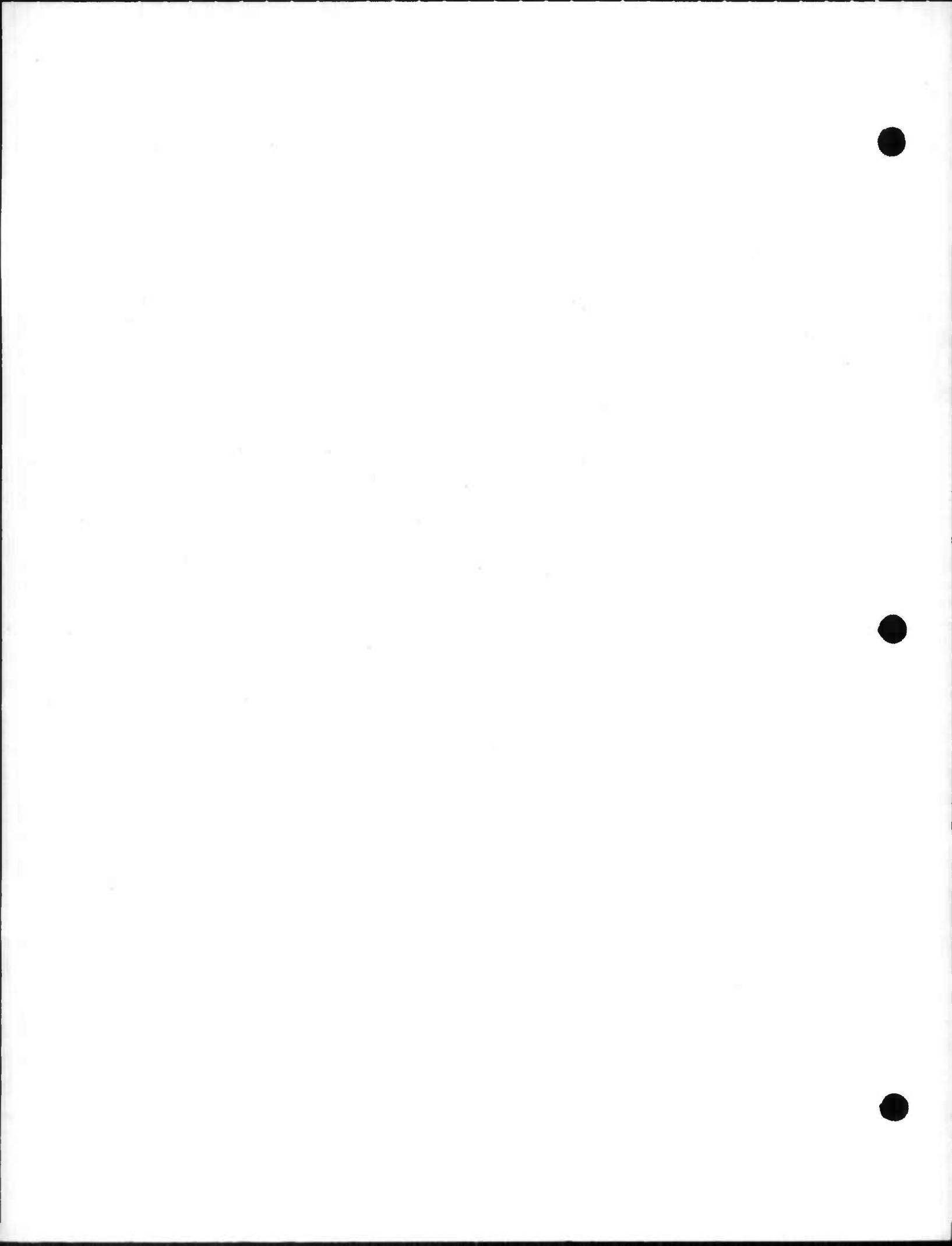
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 95 19382	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH 6 DAY 24 YEAR 95								3. TIME OF DEATH 5:40 A M	
1. DECEDENT'S NAME (First, Middle, Last) Hilda Morgan										7. DATE OF BIRTH (Month, Day, Year) 01-10-02	
4. SOCIAL SECURITY NUMBER 212-12-9148		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) MD.			
9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH N/A											
RESIDENCE OF DECEDENT											
10a. STATE MD.	10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 611 S. CHARLES STREET										10f. ZIP CODE 21230	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMEED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) UNK				16b. KIND OF BUSINESS/INDUSTRY UNB					
17. FATHER'S NAME (First, Middle, Last) JOHN MORGAN										18. MOTHER'S NAME (First, Middle, Maiden Surname) CAROLIN MORGAN	
19a. INFORMANT'S NAME (Type/Print) NAOMI FRAZIER					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 118 N. HOWARD STREET BALTO. MD. 21201						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. ZION CEMETERY					DATE 06-27-95	20c. LOCATION — City or Town, State LANSDOWNE MD.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY ALBERT P. WTLIE F/H PA 638 N. GILMOR STREET 21217	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Acute myocardial infarction suspected</i> DUE TO (OR AS A CONSEQUENCE OF): <i> </i>										24 hrs	
b. <i>Atherosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i> </i>										64 yrs	
c. <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i> </i>										54 yrs	
d. <i>Dementia</i> DUE TO (OR AS A CONSEQUENCE OF): <i> </i>										54 yrs	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 										29c. LICENSE NUMBER D30494	29d. DATE SIGNED (Month, Day, Year) 6/26/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) J. DAVIS 4110 48 60 Wilkins Ave Baltimore MD 21201											
31. DATE FILED (Month, Day, Year) JUN 2 1995		32. PRESENT ADDRESS Jean Wheeler Landale									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

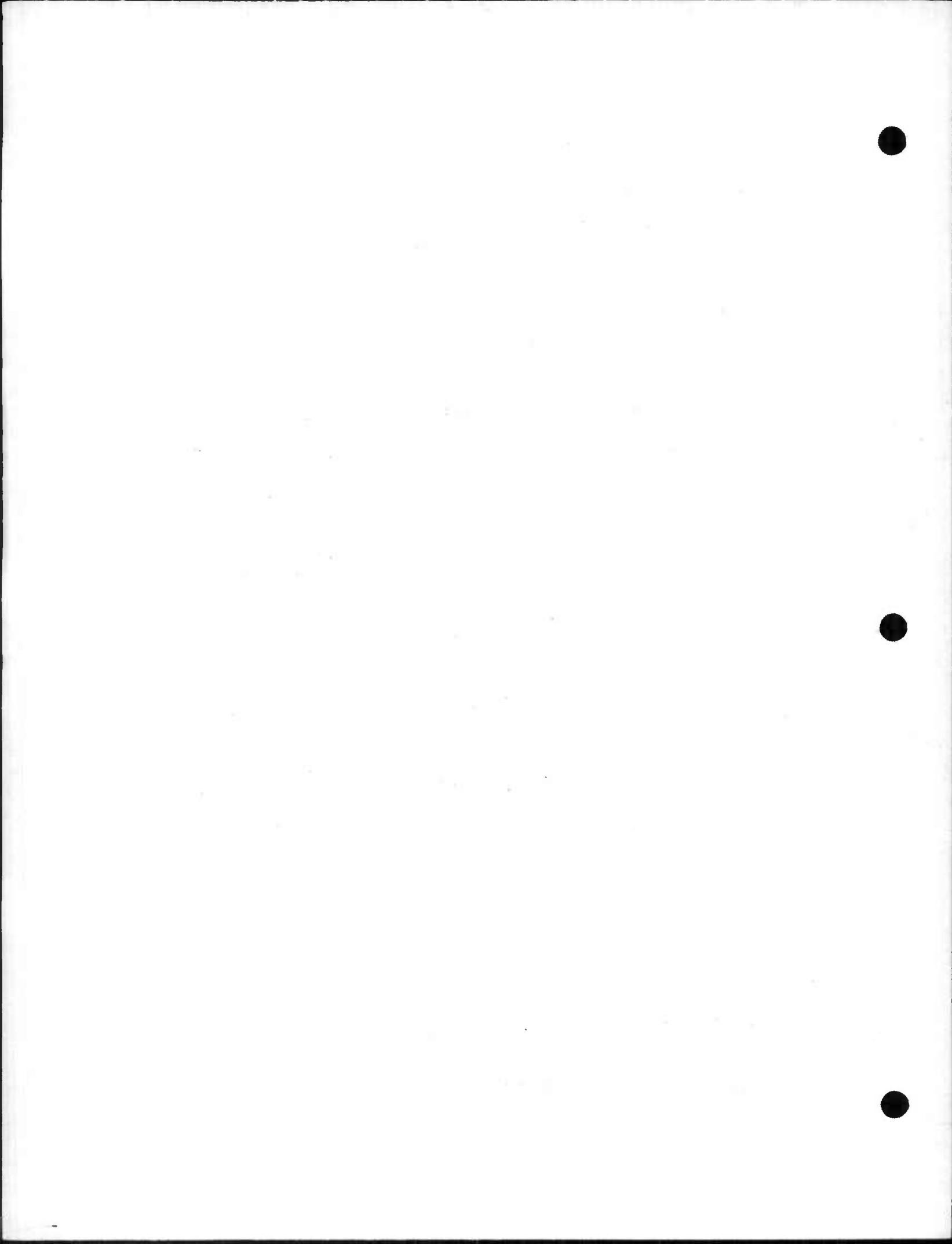
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) VIOLA ELIZABETH MORGAN										2. DATE OF DEATH MONTH JUNE DAY 15 YEAR 1995	3. TIME OF DEATH 9:55 A. M				
4. SOCIAL SECURITY NUMBER 213-05-6691		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/>	IF UNDER 24 HRS. DAYS <input type="checkbox"/>	IF HOURS <input type="checkbox"/>	IF MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) 4/27/09	8. BIRTHPLACE (State or Foreign Country) PA						
9a. FACILITY NAME (If not institution, give street and number) MERIDIAN CROMWELL				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON				9c. COUNTY OF DEATH BALTIMORE							
RESIDENCE OF DECEDENT															
10a. STATE MARYLAND	10b. COUNTY BALTIMORE	10c. CITY, TOWN OR LOCATION GLEN ARM								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER P.O. BOX 136				10f. ZIP CODE 21057				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 2 YEARS MARKETING RESEARCH			16b. KIND OF BUSINESS/INDUSTRY MARKETING										
17. FATHER'S NAME (First, Middle, Last) OSCAR RETCHHARDT				18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE McCLELLAND											
19a. INFORMANT'S NAME (Type/Print) PHYLLIS JOAN MORGAN STEVENSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 136 GLEN ARM, MD 21057											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEM. PARK			DATE 6/17/95		20c. LOCATION — City or Town, State HILLENDALE, MD								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christina L. Kowalewski</i>										22. NAME AND ADDRESS OF FACILITY JOHNSON FUNERAL HOME 8521 LOCH RAVEN BLVD. TOWSON, MD 21286					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death					
<p>a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Dementia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>C. difficile Colitis</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic Vascular Disease</i>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mariam Kowalewski MD</i>										29c. LICENSE NUMBER D21022	29d. DATE SIGNED (Month, Day, Year) ► 6-22-95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>MARIAM KOWALEWSKI 860 HARRFORD RD BALTO. MD. 21234</i>															
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE <i>Julin Shuler-Kardell</i>													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

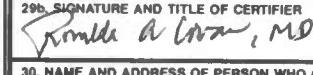
TO BE COMPLETED BY FUNERAL DIRECTOR

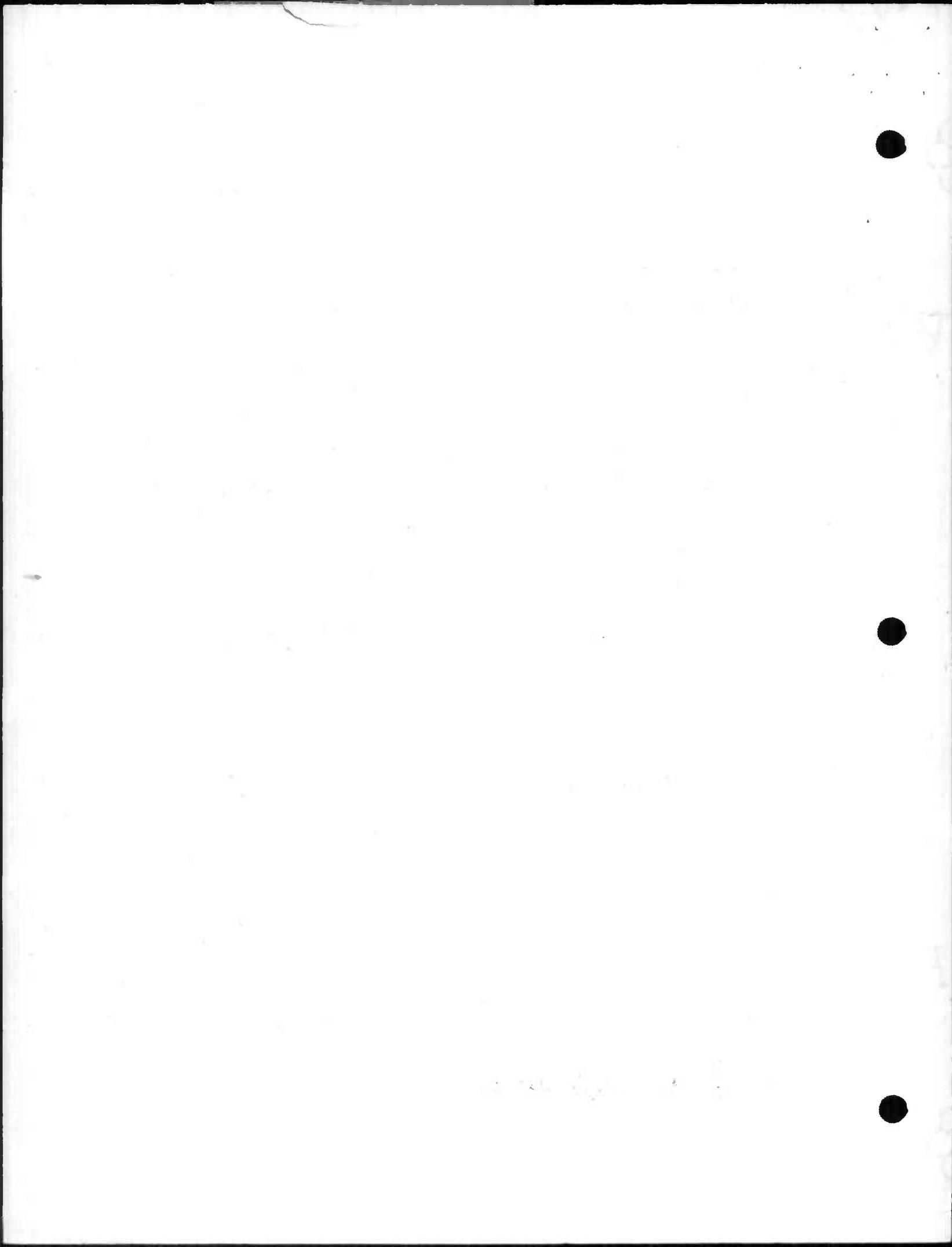
ITEMS: 1. & 22 PER F.H. FILM G-724 6/27/95 t.t.

95 19384

1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HENRY BRADLEY MITCHELL, SR.						2. DATE OF DEATH MONTH JUNE DAY 20, YEAR 1995	3. TIME OF DEATH 8:20 P M
4. SOCIAL SECURITY NUMBER 226-38-5713		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Feb. 23, 1932	8. BIRTHPLACE (State or Foreign Country) Virginia
9a. FACILITY NAME (If not institution, give street and number) Harbor Hospital Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH NA	
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY NA	10c. CITY, TOWN OR LOCATION Baltimore (Westport)				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2219 Cedley Street				10f. ZIP CODE 21230		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Groundsman		16b. KIND OF BUSINESS/INDUSTRY Asplundh Tree Co.			
17. FATHER'S NAME (First, Middle, Last) William J. Mitchell				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lilly R. Rose			
19a. INFORMANT'S NAME (Type/Print) Mrs. Margaret C. Mitchell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2219 Cedley St., Baltimore, Md. 21230			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Hill Cemetery		DATE 6/24/95	20c. LOCATION — City or Town, State Baltimore, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY McCullough Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC MALIGNANT MELANOMA Approximate Interval Between Onset and Death 3 MONTHS							
b. _____ c. _____ d. _____							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER AB-244-1614-29		29d. DATE SIGNED (Month, Day, Year) JUNE 20, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RONILDA A. COVAR 3001 S. HANOVER ST., BALTIMORE, MD 21225							
31. DATE FILLED (Month, Day, Year) JUN 27 1995 ^{2 REGISTRAR'S SIGNATURE} 							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

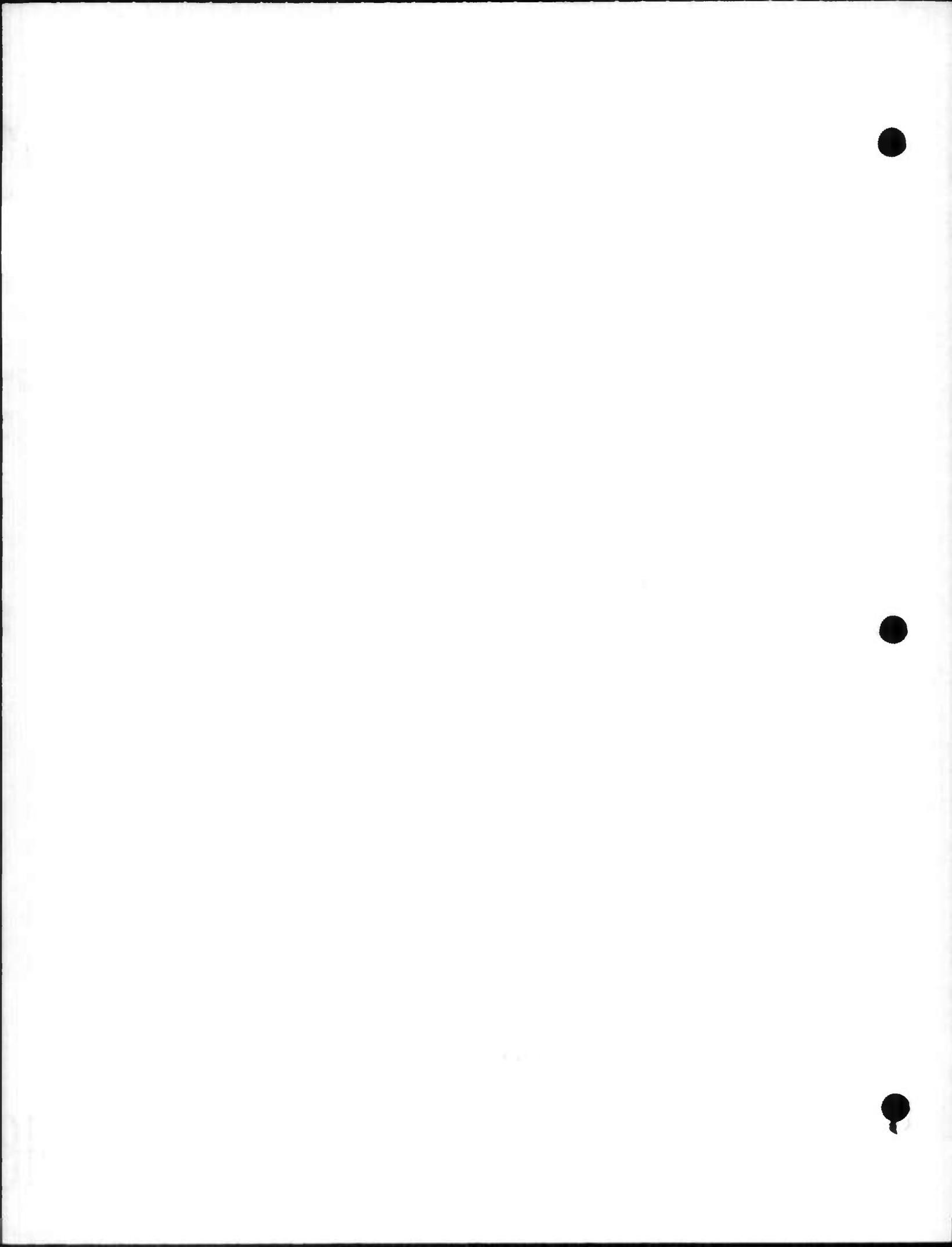
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											James Charles Miller	
4. SOCIAL SECURITY NUMBER											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
214-22-2710		S. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	June 26, 1995	7:55 a.m.					
9a. FACILITY NAME (If not institution, give street and number)											7. DATE OF BIRTH (Month, Day, Year) Oct 21 1926	8. BIRTHPLACE (State or Foreign Country) Maryland
3033 E. Northern Pkwy											9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City	9c. COUNTY OF DEATH N/A
RESIDENCE OF DECEDENT												
10a. STATE Maryland	10b. COUNTY N/A	10c. CITY, TOWN OR LOCATION Baltimore City									10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3033 E. Northern Pkwy.											10f. ZIP CODE 21214	10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1959			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4			16b. KIND OF BUSINESS/INDUSTRY Assistant Analyst			16c. LOCATION — City or Town, State United States Government				
17. FATHER'S NAME (First, Middle, Last) John M. Miller											18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Grill	
19a. INFORMANT'S NAME (Type/Print) Anna C. Miller											19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3033 E. Northern Pkwy. Baltimore, Md. 21214	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Redeemer Cemetery			DATE 6/29/95			20c. LOCATION — City or Town, State Baltimore Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Milton J. Knight Jr.											22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF):												
b. <i>Meloidoconus of Colon</i> DUE TO (OR AS A CONSEQUENCE OF):												
c. DUE TO (OR AS A CONSEQUENCE OF):												
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			26b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mouhamad Annas MD</i>		29c. LICENSE NUMBER D23427			29d. DATE SIGNED (Month, Day, Year) ► 6/26/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Mouhamad O. Annas, M.D., 3007 E Northern Pkwy. Baltimore, Maryland 21214												
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>J. Ruck</i>										



95-3694-510

L.R.B. ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-724 6/30/95 t.t.

95 19386

Item 1, 10a, f, Film 724, 6/27/95

1. STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

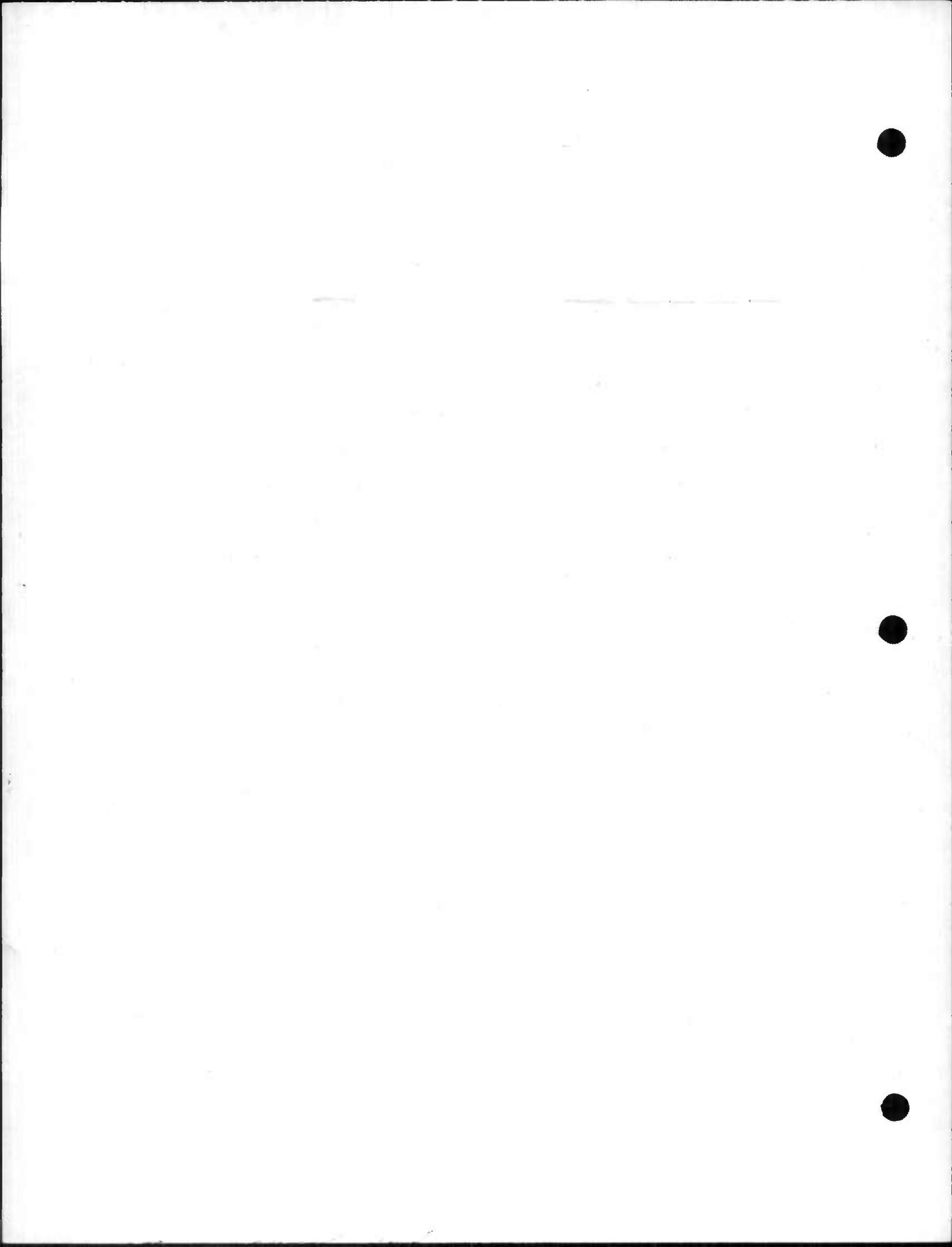
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) GORDON M. MCRAE MARTIN				2. DATE OF DEATH MONTH JUNE DAY 24 YEAR 1995	3. TIME OF DEATH 1:22A M
4. SOCIAL SECURITY NUMBER 213-60-2101		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 41 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
9e. FACILITY NAME (If not institution, give street and number) 2748 ALAMEDA				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY.	
10e. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore	
10e. STREET AND NUMBER 4617 CHATFORD AVE 4615 Park Heights Avenue				101. ZIP CODE 21215 21206	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 □ Never Married 2 □ Married 3 □ Widowed 4 X Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) College (1-4 or 5+) — Office Clerk		16b. KIND OF BUSINESS/INDUSTRY Public Defender Office	
17. FATHER'S NAME (First, Middle, Last) Moses Martin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Missie Lee	
19e. INFORMANT'S NAME (Type/Print) Missie Martin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4617 Chatford Ave./Baltimore, MD 21206	
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 X Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GARRISON FOREST VAC EM.6-29		DATE	20c. LOCATION — City or Town, State OWINGS MILLS, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bernard D Johnson				22. NAME AND ADDRESS OF FACILITY March Funeral Home-East 1101 E. North Avenue/Baltimore, MD 21202	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → NARCOTIC, ALCOHOL AND COCAINE INTOXICATION					
Approximate Interval Between Onset and Death					
<p>a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 X Residence 6 □ Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 X YES 2 □ NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 X YES 2 □ NO
27. MANNER OF DEATH 1 □ Natural 5 □ Pending Investigation 2 □ Accident 3 □ Suicide 4 □ Homicide 8 X Could not be determined		28e. DATE OF INJURY (Month, Day, Year) 6-24-95	28f. TIME OF INJURY FOUND: 1:15 AM	28c. INJURY AT WORK? 1 □ YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) FOUND: PRIVATE DWELLING		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2748 ALAMEDA BALTIMORE CITY, MD			
29e. CERTIFIER (Check only) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
30. SIGNATURE AND TITLE OF CERTIFIER Amerson				29c. LICENSE NUMBER O.C.M.E.	29d. DATE SIGNED (Month, Day, Year) JUNE 24, 1995
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE J. McRae			

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 28 is marked, or Item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

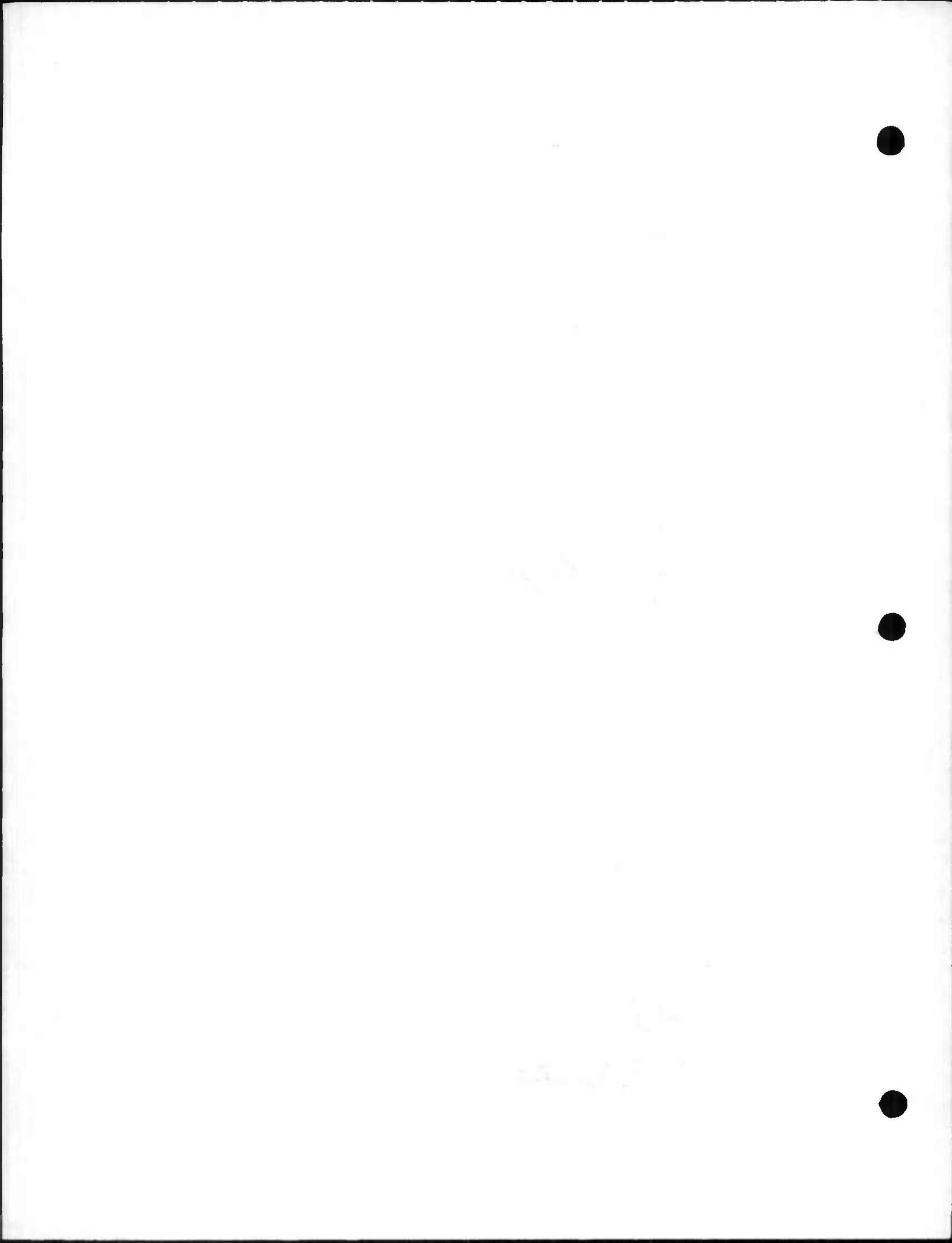
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <i>Daniel Partyka</i>											2. DATE OF DEATH MONTH June 23 YEAR 95	3. TIME OF DEATH 3:19 A.M.	
4. SOCIAL SECURITY NUMBER 070-22-3047		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) May 31, 1929			B. BIRTHPLACE (State or Foreign Country) NY		
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A					
RESIDENCE OF DECEDENT													
10a. STATE MD	10b. COUNTY Howard	10c. CITY, TOWN OR LOCATION Columbia								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 9243 Feathered Head				10f. ZIP CODE 21045				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korean			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) None Machinist			16b. KIND OF BUSINESS/INDUSTRY Lever Brother Soap Company								
17. FATHER'S NAME (First, Middle, Last) Joseph J. Partyka				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Mentlewski									
19a. INFORMANT'S NAME (Type/Print) Ronald Bodolay (Friend)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9243 Feathered Head, Columbia, MD 21045									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Meadowridge Mem. Park		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park			June 27, 1995	DATE	20c. LOCATION — City or Town, State Dorsey, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. C. Witzke</i>				22. NAME AND ADDRESS OF FACILITY Leroy M. & Russell C. Witzke Funeral Home 5555 Twin Knolls Road, Columbia, MD 21045									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ventricular Fibrillation Arrest</i> DUE TO (OR AS A CONSEQUENCE OF) b. <i>Mycocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF) c. _____ DUE TO (OR AS A CONSEQUENCE OF) d. _____											30 min 8 days		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year) 26b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 26d. DESCRIBE HOW INJURY OCCURRED 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											29c. LICENSE NUMBER 7205		29d. DATE SIGNED (Month, Day, Year) June 23 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Ardizzi 22 South Greene Street</i>											31. DATE FILED (Month, Day, Year) JUN 27 1995		
32. REGISTRATION NUMBER <i>Jahn</i>											DHMH-16 Rev 1/89		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

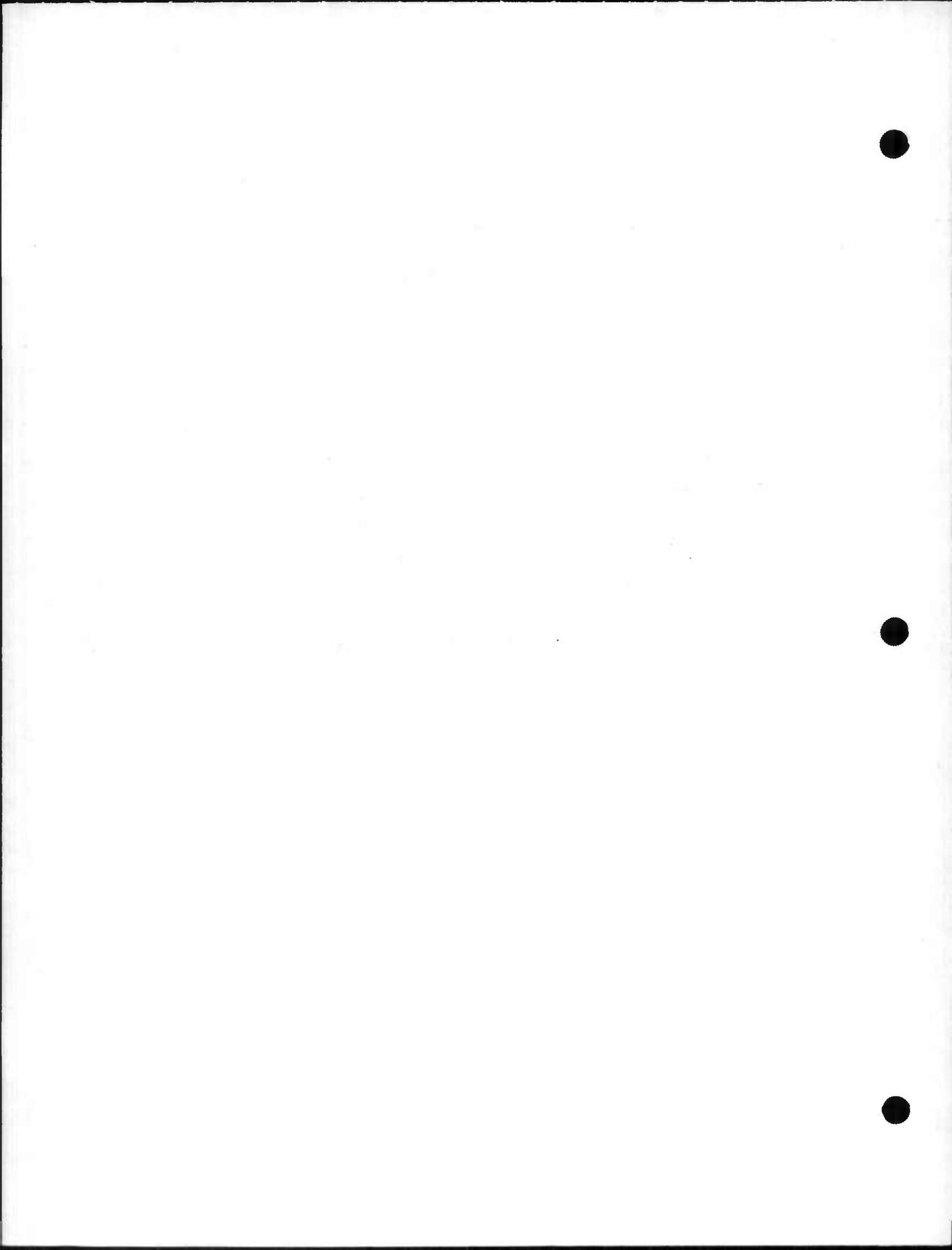
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) William DuVal Purkins , Sr.												2. DATE OF DEATH MONTH DAY YEAR June 25 1995	3. TIME OF DEATH 8:35 A. M.		
4. SOCIAL SECURITY NUMBER 218-03-5594		5. SEX 1 X M 2 F		6. AGE (In yrs. last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH Month Day Year October 17, 1913		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Baltimore , Maryland						9c. COUNTY OF DEATH N/A			
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore , Maryland						10d. INSIDE CITY LIMITS? 1 X YES 2 NO					
10e. STREET AND NUMBER 4706 Bayonne Ave.						10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Transportation Specialist			16b. KIND OF BUSINESS/INDUSTRY G.A.O.									
17. FATHER'S NAME (First, Middle, Last) William Purkins						18. MOTHER'S NAME (First, Middle, Maiden Surname) Vesta Gohl									
19a. INFORMANT'S NAME (Type/Print) Mrs. Frances E. Purkins						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as 10e									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Gardens of Faith Cemetery						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith Cemetery		DATE 6/29/95		20c. LOCATION — City or Town, State Balto. Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald C. Selby Jr.						22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Funeral Home, Inc. 5305 Harford Road . Balto. Md. 21214									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Cardiac arrest DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. c. d.												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 1												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO GR		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO GR	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) GR												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide			28a. DATE OF INJURY (Month, Day, Year) N/A			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED N/A					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A												
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Shelia Carroll			29c. LICENSE NUMBER D46595			29d. DATE SIGNED (Month, Day, Year) 6/26/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary Carroll M.D. 6801 BelAir Rd. 21206						31. DATE FILED (Month, Day, Year) JUN 27 1995									
3 REGULAR SIGNATURE						3 REGULAR SIGNATURE									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

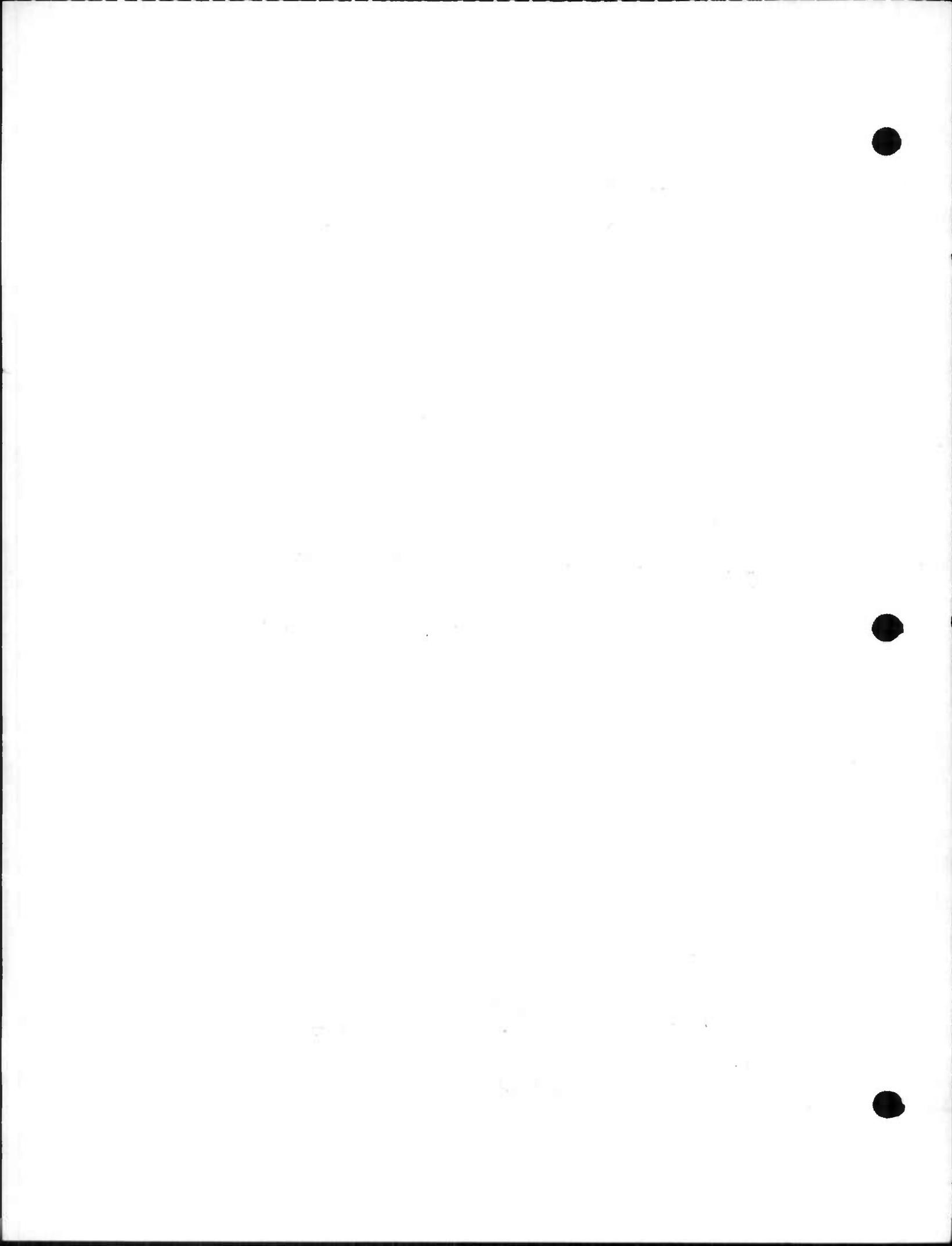
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)		Ralph Peed						2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH		
RALPH								6 20 95		10 AM		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)		
215-14-9791		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	109 YRS.	MONTHS		DAYS		MONTH, DAY, YEAR		Md		
9a. FACILITY NAME (If not institution, give street and number)		1046 N. Eden St						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH		
10e. STATE		10b. COUNTY		N. A						BALTO.		
Md		N. A		BALTO						N. A		
10d. INSIDE CITY LIMITS?		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO										
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?		11. S. A		
1046 N. Eden St		21205						11. S. A				
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES						13. WAS DECEASED OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify: Black		
2 <input checked="" type="checkbox"/> Never Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		N. A						1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)						16b. KIND OF BUSINESS/INDUSTRY				
Elementary/Secondary (0-12)		Guard (R)						Md. Penitentiary				
17. MOTHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)						19. INFORMANT'S NAME (Type/Print)				
Raphael Peed		MARY Mitchell						John B. Myers				
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						19c. LOCATION — City or Town, State				
John B. Myers		1682 Ruxton Ave BALTO. MD 21216						Baltimore, MD				
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place)						DATE		20c. LOCATION — City or Town, State		
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Greenmount Crematorium Plan						6/22		Baltimore, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY										
Joseph B. Locks, Jr.		Locks Funeral Home 1304 N. Central St										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death										
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		ASCVD - Atherosclerotic cardio-vascular disease										
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		SAME										
b.		DUE TO (OR AS A CONSEQUENCE OF):										
c.		DUE TO (OR AS A CONSEQUENCE OF):										
d.		DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?										
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO										
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)										
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one)		1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER		David Silver						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		2323 Orleans St. Baltimore						H43234		► JUNE 22, 1995		
31. DATE FILED (Month, Day, Year)		JUN 27 1995						32. REGISTRAR'S SIGNATURE				



DIVISION OF VITAL RECORDS, P.O. BOX 68766

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

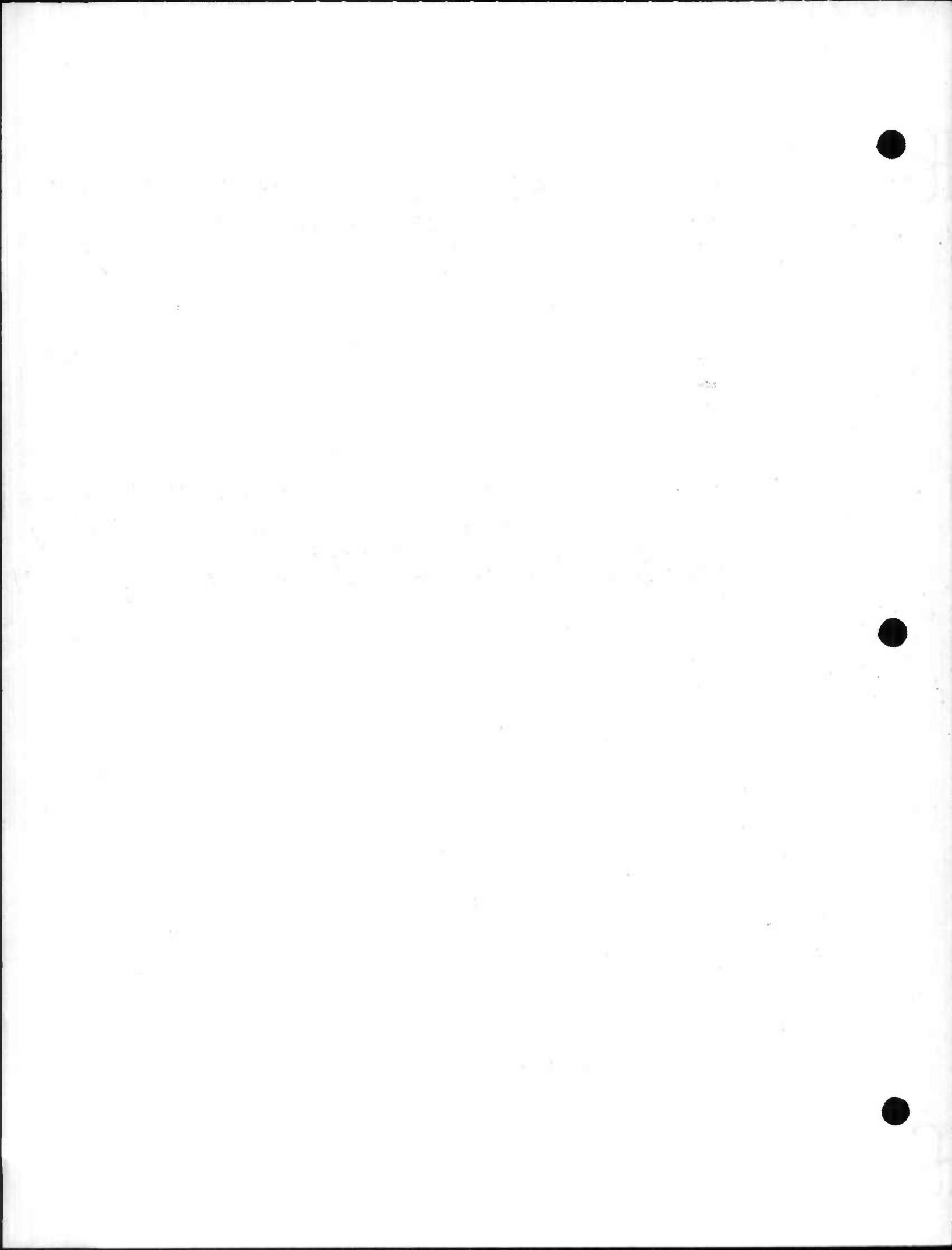
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR											
1. DECEDENT'S NAME (First, Middle, Last) John Pierce										2. DATE OF DEATH MONTH June DAY 18 YEAR 1995	3. TIME OF DEATH 1306 M
4. SOCIAL SECURITY NUMBER 578-46-3658		5. SEX M	6. AGE (In yrs. last birthday) 59 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH Month Sept Day 17 Year 1935		8. BIRTHPLACE (State or Foreign Country) Wash. D.C.	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City								9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY	10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? Y YES N NO	
10e. STREET AND NUMBER 22 S. Athol Avenue		10f. ZIP CODE 21229								10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced unk		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES unk				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: unk				14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) unk								16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) unk										18. MOTHER'S NAME (First, Middle, Maiden Surname) unk	
19a. INFORMANT'S NAME (Type/Print) Sheria Williams		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 22 S. Athol Ave. Baltimore, Md 21229									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) unk		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery or other place) Zion Cem.								DATE 6/27	20c. LOCATION — City or Town, State Baltimore, Md.
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Blanca Adams Jones		22. NAME AND ADDRESS OF FACILITY MARSHALL W. Jones, JR F H RA-4101 Edmondson Ave. Baltimore, Md 21229									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bilat. pneumonia										7 day	
b. Empyema DUE TO (OR AS A CONSEQUENCE OF):										2 more	
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ex. of Old Tuberculosis										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER John Pierce										29c. LICENSE NUMBER D25044	29d. DATE SIGNED (Month, Day, Year) June 18, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Pierce											
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE									



BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

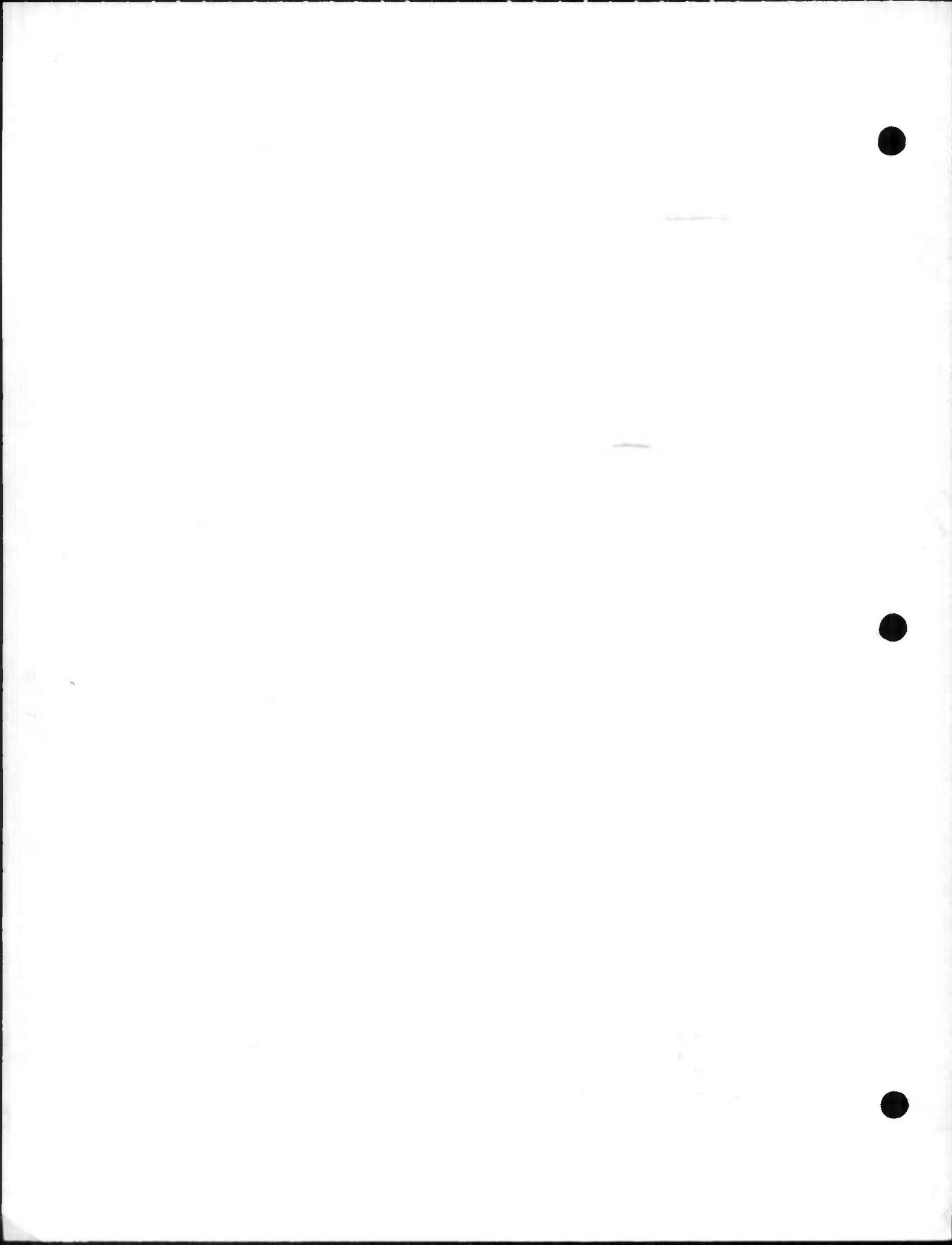
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)		SALLIE OWENS						2. DATE OF DEATH MONTH 06		DAY 23	YEAR 95	3. TIME OF DEATH 0500 AM	
4. SOCIAL SECURITY NUMBER 219-14-0360		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0		7. DATE OF BIRTH (Month, Day, Year) MAR. 9, 1918		8. BIRTHPLACE (State or Foreign Country) S. C AROLINA	
9a. FACILITY NAME (If not institution, give street and number) Bayview HOSPITAL								9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH n/a			
RESIDENCE OF DECEASED													
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 3578 DUDLEY AVENUE						10f. ZIP CODE 21213				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) -				16b. KIND OF BUSINESS/INDUSTRY DOMESTIC				16c. LOCATION — City or Town, State out of home			
17. FATHER'S NAME (First, Middle, Last) JOHN OWENS						18. MOTHER'S NAME (First, Middle, Maiden Surname) JANIE SMALL							
19a. INFORMANT'S NAME (Type/Print) CATHERINE GOODE						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3578 DUDLEY AVENUE, BALTIMORE, MD 21213							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) KING MEMORIAL PARK				DATE 6-28		20c. LOCATION — City or Town, State RANDALLSTOWN, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bernard D Johnson						22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. Enter only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
s. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):													
b. SEPSIS & Pneumonia/Urinary Tract Infection DUE TO (OR AS A CONSEQUENCE OF):													
c. HYPOTENSION DUE TO (OR AS A CONSEQUENCE OF):													
d. HYPOTENSION DUE TO (OR AS A CONSEQUENCE OF):													
Approximate Interval Between Onset and Death 4 mos													
2 days													
1 day													
12 hrs													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
CVA → L Hemiparesis Cardiomyopathy													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Ngc - Ha Nguyen, MD											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 N. Wolfe St. Baltimore, MD 21205		29c. LICENSE NUMBER L8085		29d. DATE SIGNED (Month, Day, Year) 6/23/95									
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Jeanine Wanda Reddell											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

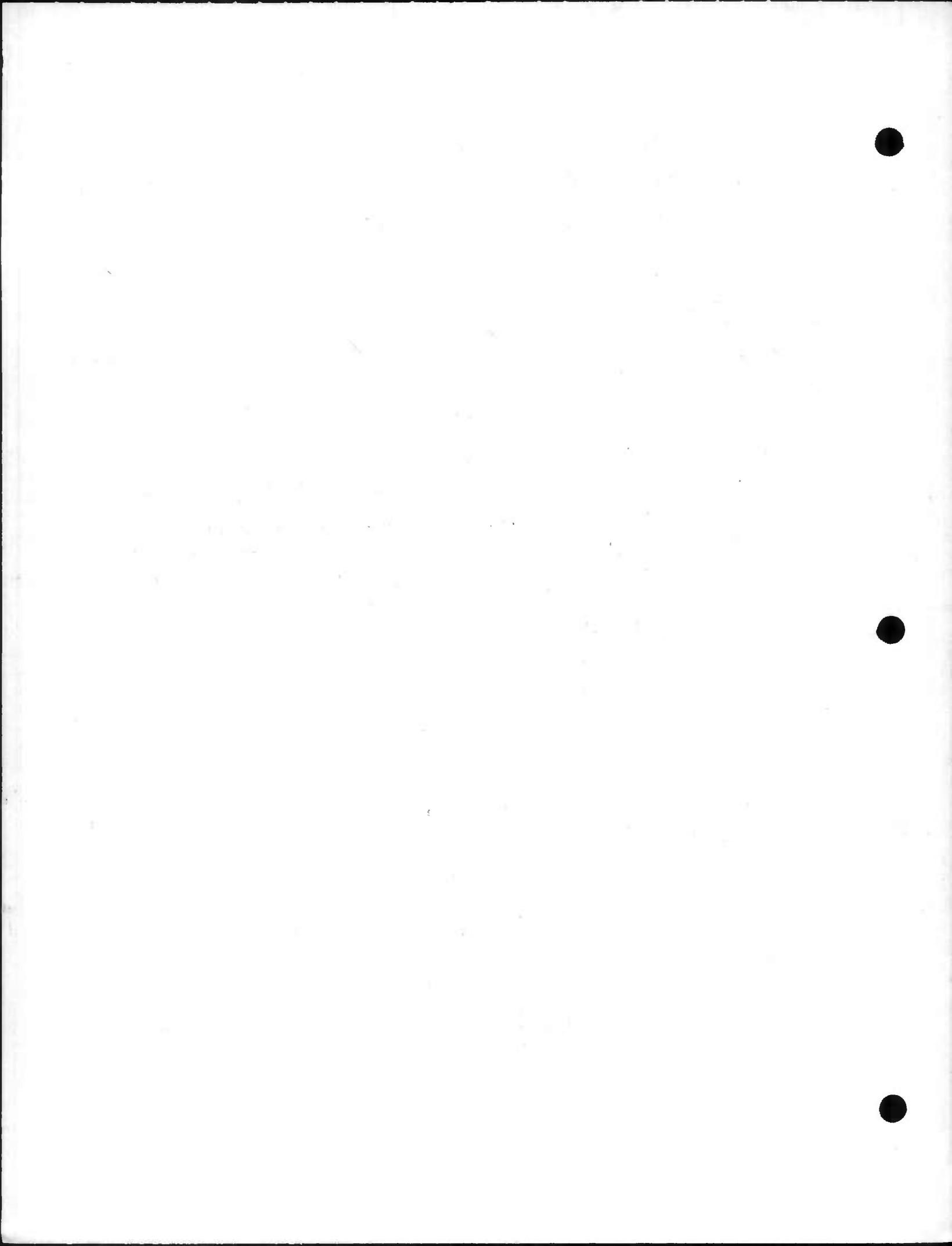
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											95 19392	
Jane Victoria Osman												
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF DEATH	DAY	YEAR	3. TIME OF DEATH			
192-07-2992		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	78 YRS.	MONTHS	DAYS	JUNE	23	95	8:58 A.M.			
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH				7. DATE OF BIRTH (Month, Day, Year)			8. BIRTHPLACE (State or Foreign Country)			
HARBOR HOSPITAL CENTER		BALTIMORE				3-27-1917			PENNSYLVANIA			
9c. COUNTY OF DEATH											N/A	
RESIDENCE OF DECEDENT												
10a. STATE	10b. COUNTY	10c. CITY, TOWNS OR LOCATION				10d. INSIDE CITY LIMITS?						
MARYLAND	N/A	BALTIMORE				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER				10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?					
607 EAST 33RD STREET				21218			U.S.A.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE				
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
16. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+)			HAIRDRESSER			HAIRDRESSER				
2												
17. FATHER'S NAME (First, Middle, Last)					18. MOTHER'S NAME (First, Middle, Maiden Surname)							
JOHN C. NELSON					ANNA AXELSON							
19a. INFORMANT'S NAME (Type/Print)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
SHEILA MEHRING					607 EAST 33RD STREET BALTO., MD. 21218.							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE	20c. LOCATION — City or Town, State			
					GREEN MOUNT CREMATORIAL			6/95	BALTO., MD.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>► William R. Lauer III</i>					22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS & SONS CO. 4905 YORK RD. BALTO., MD. 21212.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):											7 days	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>Chronic obstructive lung Disease</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Chronic steroid therapy</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Rheumatoid Arthritis</i> DUE TO (OR AS A CONSEQUENCE OF):											3 years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic steroid therapy</i> <i>Rheumatoid Arthritis</i>											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Shahriar T. Tabasi</i>		Harbor Hospital CTR			29c. LICENSE NUMBER 2441614 - 28			29d. DATE SIGNED (Month, Day, Year) ► June 23rd 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SHAHRIAR T. TABASI Harbor Hospital 3001 South Hanover St Baltimore MD 21225</i>												
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRATION NO.										



95 19393

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) HYMAN RUBIN				2. DATE OF DEATH MONTH DAY YEAR JUNE 21, 1995	3. TIME OF DEATH 8 pm		
4. SOCIAL SECURITY NUMBER 075-28-9016		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 91 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) OCT. 23, 1903	8. BIRTHPLACE (State or Foreign Country) POLAND	
8a. FACILITY NAME (If not institution, give street and number) JEWISH CONVALESCENT HOME				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEASED							
10a. STATE MARYLAND	10b. COUNTY BALTIMORE	10c. CITY, TOWN OR LOCATION RANDALLSTOWN			10d. INSIDE CITY LIMITS? 1 X YES 2 NO		
10e. STREET AND NUMBER 12 CAMANO COURT			10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 □ Never Married 2 □ Married 3 X Widowed 4 □ Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES 8		13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working Do NOT use retired.) OWNER OPERATOR		16b. KIND OF BUSINESS/INDUSTRY FISH MARKET			
17. FATHER'S NAME (First, Middle, Last) MAX RUBIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) GOLDA UNKNOWN			
19a. INFORMANT'S NAME (Type/Print) MR. SIDNEY RUBIN			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 CAMANO COURT RANDALLSTOWN, MD 21133				
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 X Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) UNITED HEBREW		DATE 6-23-1995	20c. LOCATION — City or Town, State STATEN ISLAND, N.Y.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Alan Lewis</i>						22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 3 yr	
b. Dementia DUE TO (OR AS A CONSEQUENCE OF):						1 yr	
c. Atherosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF):						3 yrs	
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Dementia						24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 □ NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES □ NO □ UNCERTAIN □							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 □ NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)					
27. MANNER OF DEATH 1 □ Natural 5 □ Pending investigation 2 □ Accident 6 □ Homicide 3 □ Suicide 7 □ Could not be determined 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 □ CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Kroopnick M.D.</i>				29c. LICENSE NUMBER 017753	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT KROOPNICK, M.D. 8620 LIBERTY RD. RANDALLSTOWN, MD 21133		31. DATE FILED (Month, Day, Year) JUN 27 1995				29d. DATE SIGNED (Month, Day, Year) ► 6/22/95	
		32. REGISTRAR'S SIGNATURE <i>John Dawson-Kendall</i>					

BALTIMORE, MARYLAND 21215-0020

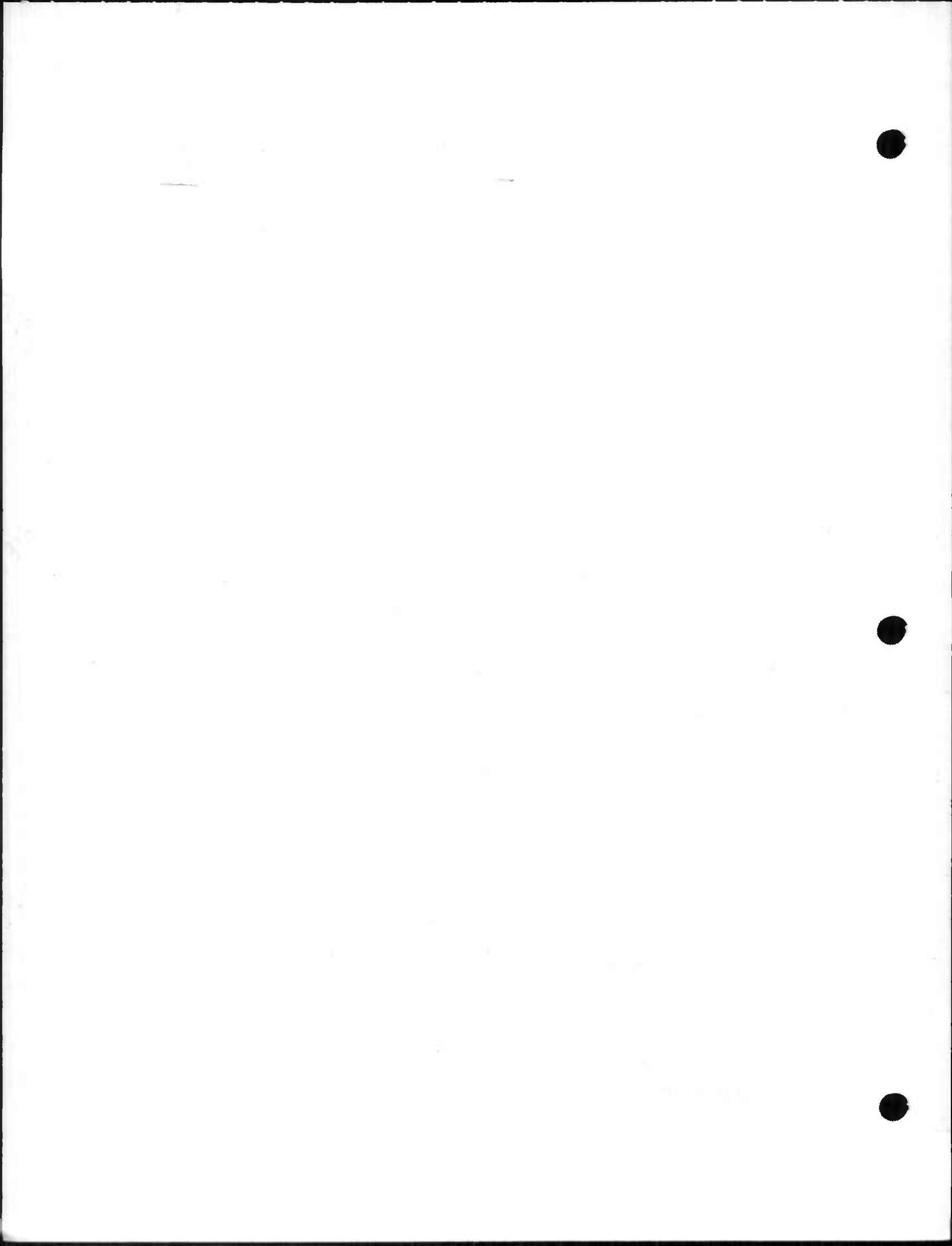
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19394

1. DECEDENT'S NAME (First, Middle, Last) Vera Resau						2. DATE OF DEATH MONTH DAY June 23 95	3. TIME OF DEATH 10:38p
4. SOCIAL SECURITY NUMBER 220-09-3116		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Nov. 17, 1913	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) Union Memorial Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City			9c. COUNTY OF DEATH, Balto. City	
10e. STATE Maryland		10b. COUNTY Baltimore City		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2211 W. Rogers Avenue				10f. ZIP CODE 21209		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: white		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) Breston H. Resau				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ione Ramey			
19a. INFORMANT'S NAME (Type/Print) The Wesley Home				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 W. Rogers Avenue Baltimore, Maryland 21209			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Parkwood Cemetery		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery			DATE 6/27	20c. LOCATION — City or Town, State Parkville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Tracy Hens Carpenter				22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pulmonary Embolus DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 3 hours							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. S/p Coronary Artery Bypass Surgery Coronary Artery Disease							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John A. Walsh		29c. LICENSE NUMBER D 20586		29d. DATE SIGNED (Month, Day, Year) June 23, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John A. Walsh Union Memorial Hospital Baltimore, Md.							
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Lubin Shulman-Randall					

1000

1000

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

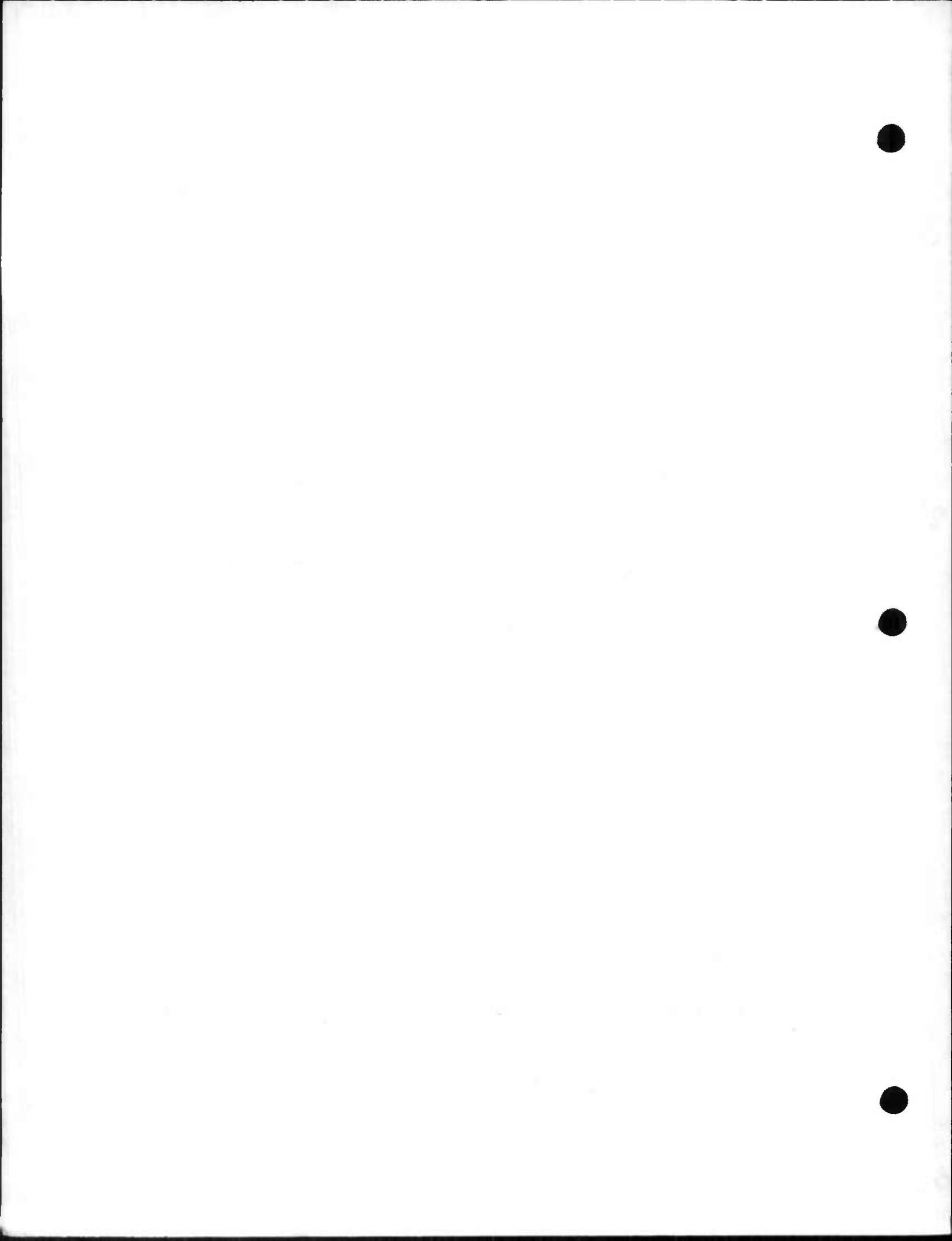
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH 06 DAY 23 YEAR 95										3. TIME OF DEATH 1:30A	
1. DECEDENT'S NAME (First, Middle, Last) EDNA ROYAL												7. DATE OF BIRTH (Month, Day, Year) 1/9/19	8. BIRTHPLACE (State or Foreign Country) Maryland
4. SOCIAL SECURITY NUMBER 214-05-2576		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	9b. CITY, TOWN OR LOCATION OF DEATH Johns Hopkins Geriatric Center Baltimore	9c. COUNTY OF DEATH Baltimore City						
9a. FACILITY NAME (If not institution, give street and number) Johns Hopkins Geriatric Center Baltimore												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE MD		10b. COUNTY Baltimore City		10c. CITY, TOWN OR LOCATION Baltimore		10f. ZIP CODE 21211		10g. CITIZEN OF WHAT COUNTRY? USA					
10e. STREET AND NUMBER 1166 Foxwood Lane													
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES None		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Beautician		16b. KIND OF BUSINESS/INDUSTRY Cosmetology									
17. FATHER'S NAME (First, Middle, Last) Wilton Hignutt		18. MOTHER'S NAME (First, Middle, Maiden Surname) Frances Maddrick											
19a. INFORMANT'S NAME (Type/Print) Carol Petree		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1166 Foxwood Lane, Baltimore, MD 21211											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hillcrest Cemetery		DATE 6/26	20c. LOCATION — City or Town, State Annapolis, MD								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Theresa A. Hauderby		22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death Years	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → COPD													
a. DUE TO (OR AS A CONSEQUENCE OF): Sepsis													
b. DUE TO (OR AS A CONSEQUENCE OF): 													
c. DUE TO (OR AS A CONSEQUENCE OF): 													
d. DUE TO (OR AS A CONSEQUENCE OF): 													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Ventilatory Dependence, history of myocardial infarction												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29d. DATE SIGNED (Month, Day, Year) ► 6.23.95	
29b. SIGNATURE AND TITLE OF CERTIFIER Anne Brown		29c. LICENSE NUMBER D41955											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 Wolfe Street, Baltimore, MD													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Judy Shuler Randell											

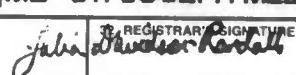


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION**TO BE COMPLETED BY FUNERAL DIRECTOR**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR Jun 23 1995										3. TIME OF DEATH 4:36 am		
1. DECEDENT'S NAME (First, Middle, Last) WAYNE KENNETH REDDING														
4. SOCIAL SECURITY NUMBER 215-42-6905		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 51	YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 8-19-43	8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not Institution, give street and number) Saint Joseph Medical Center												9b. CITY, TOWN OR LOCATION OF DEATH Towson, Maryland	9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT														
10a. STATE Maryland	10b. COUNTY Baltimore	10c. CITY, TOWN OR LOCATION Glen Arm										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 12812 Ponderosa Lane					10f. ZIP CODE 21057					10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 2 yrs			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Broker				16b. KIND OF BUSINESS/INDUSTRY Real Estate						
17. FATHER'S NAME (First, Middle, Last) John S. Redding						18. MOTHER'S NAME (First, Middle, Maiden Surname) Geraldine Elvie								
19a. INFORMANT'S NAME (Type/Print) Sharon J. Redding						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12812 Ponderosa Lane Glen Arm, Md. 21057								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Dulaney Valley Mem. Gardens			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6-28 Timonium, Md.			DATE		20c. LOCATION — City or Town, State Ruck Towson Funeral Home, Inc.						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY 1050 York Rd. Towson, Md. 21204											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death 7 HOURS	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE														
a. DUE TO (OR AS A CONSEQUENCE OF): AORTIC STENOSIS														
b. DUE TO (OR AS A CONSEQUENCE OF): CORONARY ARTERY DISEASE														
c. DUE TO (OR AS A CONSEQUENCE OF): DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CORONARY ARTERY DISEASE														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Hospital: Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) Francis Khoo, MD											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED At home, farm, street, factory, office					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Francis Khoo, MD St. Joseph Medical Center Towson, MD 21204									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS KHOO, MD ST. JOSEPH MEDICAL CENTER TOWSON, MD 21204		31. DATE FILED (Month, Day, Year) JUN 27 1995			32. REGISTRAR'S SIGNATURE 			33. LICENSE NUMBER D 30263		34. DATE SIGNED (Month, Day, Year) 6-23-95				

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

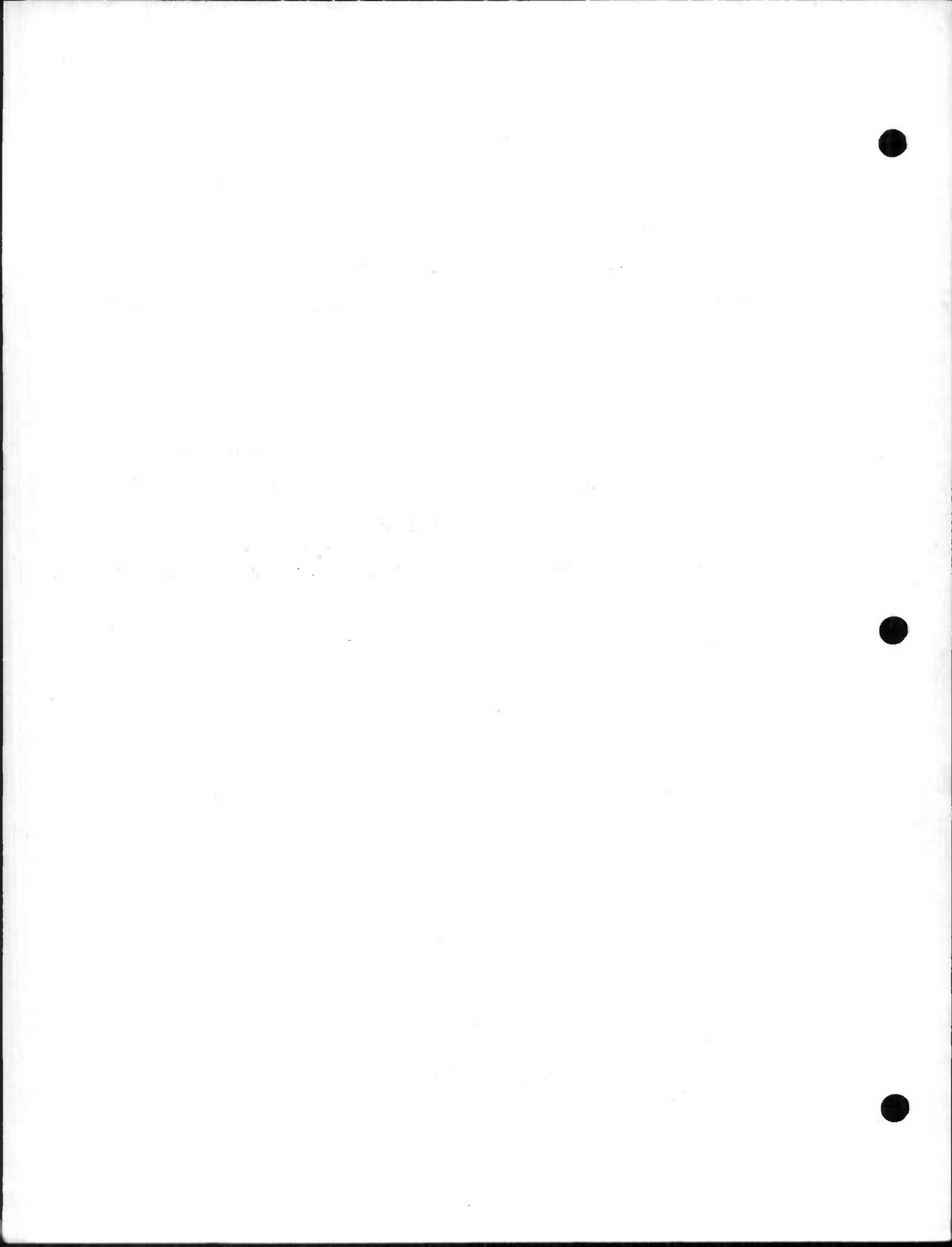
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH JUNE DAY 26 th YEAR 95	3. TIME OF DEATH 2:45 A M		
JOHN J Reese													
4. SOCIAL SECURITY NUMBER 219-14-2161		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) December 2, 1919		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not Institution, give street and number) St. Agnes Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore								9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEDENT													
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 439 Random Road		10f. ZIP CODE 21229								10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Bartender				16b. KIND OF BUSINESS/INDUSTRY Restaurant							
17. FATHER'S NAME (First, Middle, Last) William Perry Reese										18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Baker			
19a. INFORMANT'S NAME (Type/Print) Mrs. Catherine M. Russell		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5313 Carter Avenue Baltimore, Maryland 21214											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 6/29/95				DATE 6/29/95		20c. LOCATION — City or Town, State Baltimore, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Mark T. Zavonna ► Mark T. Zavonna		22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc. 5305 Harford Road Baltimore, Md. 21214											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST										5 yr.			
a. Congestive heart failure DUE TO (OR AS A CONSEQUENCE OF): Severe Aortic Stenosis / Mitral Stenosis / Mitral Regurgitation 5 yrs.										5 yrs.			
b. DUE TO (OR AS A CONSEQUENCE OF): Coronary artery Disease										2 yrs.			
c. DUE TO (OR AS A CONSEQUENCE OF):													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Usha VelMourougan										29c. LICENSE NUMBER A08125	29d. DATE SIGNED (Month, Day, Year) ► 6/26/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Usha VelMourougan, 900 Catons Ave, BALTO MD 21229													
31. DATE FILED (Month, Day, Year) 6/26/95		32. REGISTRAR'S SIGNATURE John Andrew Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

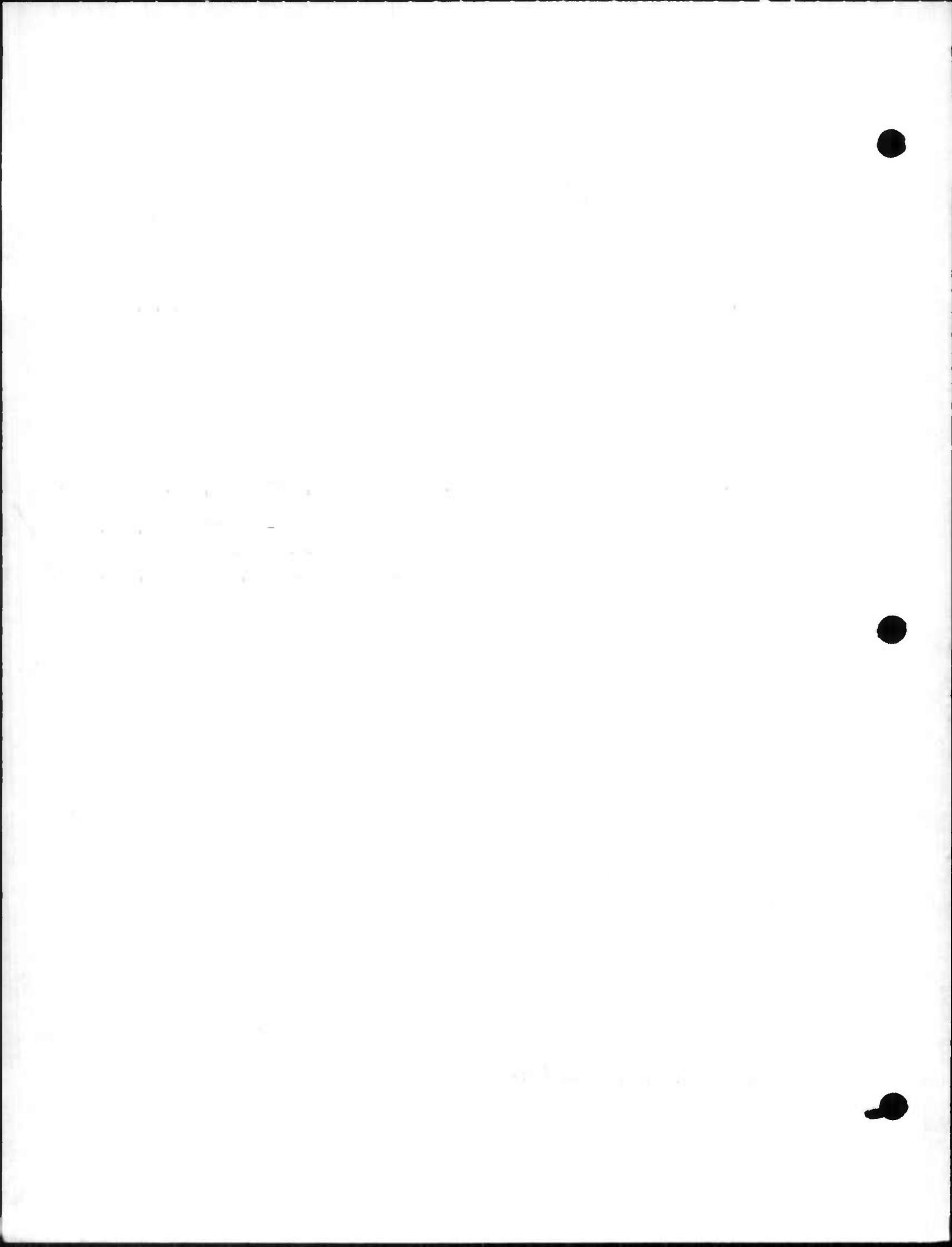
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 95 19398			
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH 06 DAY 22 YEAR 95										3. TIME OF DEATH 11:57 AM			
1. DECEDENT'S NAME (First, Middle, Last) <i>Anna Rydzynski</i>												7. DATE OF BIRTH (Month, Day, Year) <i>2-2-18</i>		8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>	
4. SOCIAL SECURITY NUMBER <i>21420 3381</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77 YRS.</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
9a. FACILITY NAME (If not institution, give street and number) <i>JHGC</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>										9c. COUNTY OF DEATH <i>Baltimore City</i>			
RESIDENCE OF DECEDENT															
10a. STATE <i>Maryland</i>	10b. COUNTY <i>N/A</i>	10c. CITY, TOWN OR LOCATION <i>Baltimore</i>										10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>500 S. Curley Street</i>					10f. ZIP CODE <i>21224</i>					10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Saleslady</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Retail</i>										
17. FATHER'S NAME (First, Middle, Last) <i>Andrew Dzierwinski</i>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Manizak</i>										
19a. INFORMANT'S NAME (Type/Print) <i>John T. Rydzynski</i>					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>500 S. Curley Street, Baltimore, Md. 21224</i>										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Holy Rosary Cemetery</i>			DATE <i>6-26</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ann S. Matthews</i>		22. NAME AND ADDRESS OF FACILITY <i>Matthews Funeral Home 3021 Eastern Avenue, Baltimore, Md. 21224</i>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>COPD</i>												<i>years</i>			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. <i>COPD</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>CHF</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Thromboembolic</i> DUE TO (OR AS A CONSEQUENCE OF): d. <i>Dementia</i>												<i>years</i> <i>weeks</i> <i>years</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Chronic Renal Failure</i>															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>—</i>			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <i>—</i>						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>—</i>			28d. LOCATION (Street and Number or Rural Route Number, City or Town, State) <i>—</i>										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Rydzynski</i>		29c. LICENSE NUMBER <i>D38670</i>			29d. DATE SIGNED (Month, Day, Year) <i>6/22/95</i>										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Hopkins Bayview Medical Center</i>															
31. DATE FILLED IN <i>JUN 27 1995</i>															



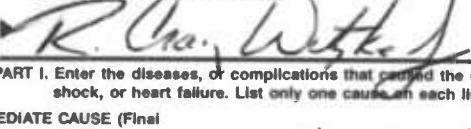
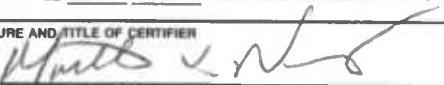
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

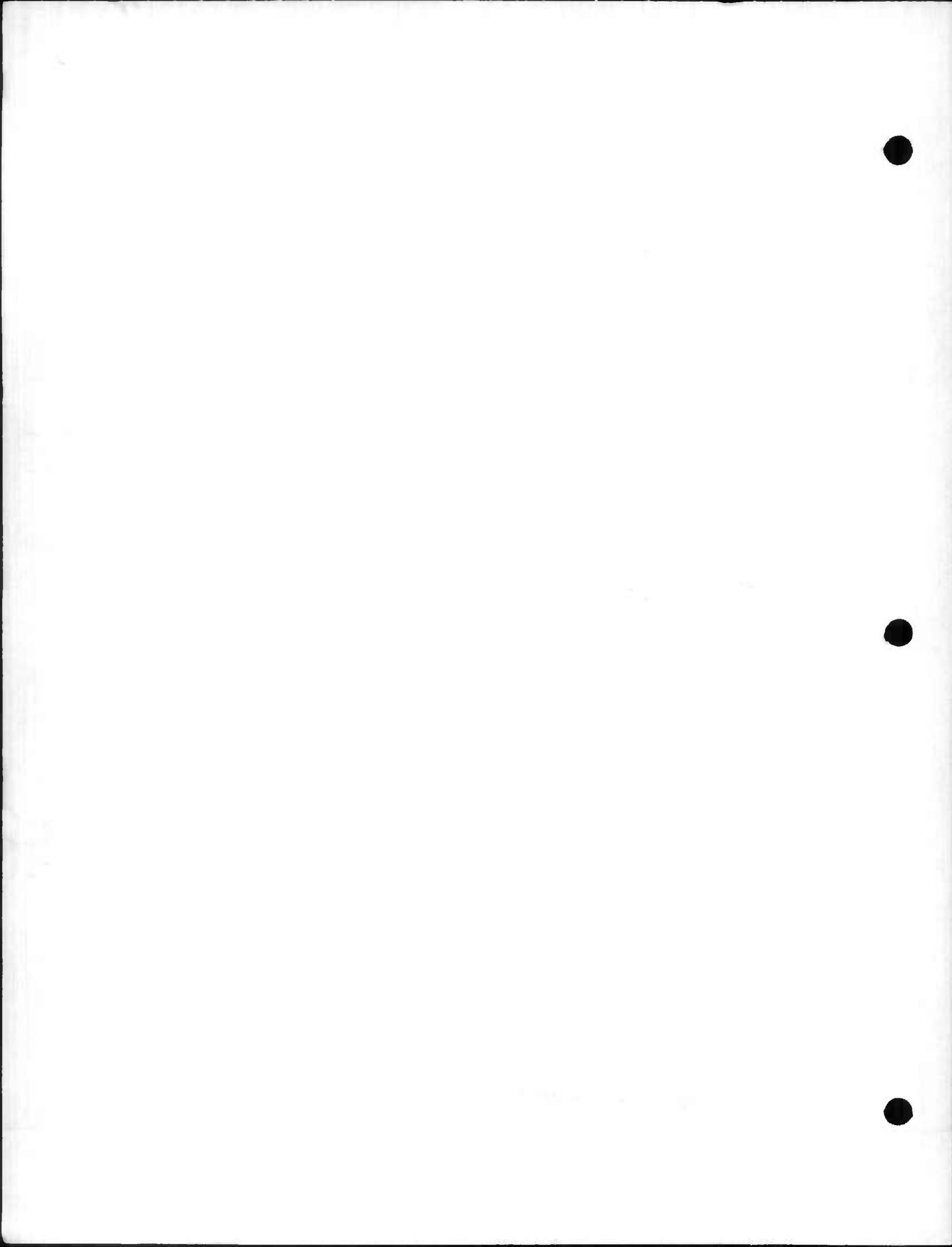
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Stanley Shinn						2. DATE OF DEATH MONTH DAY YEAR June 24 1995		3. TIME OF DEATH 7:00P M	
4. SOCIAL SECURITY NUMBER 214-01-0307		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 12, 1910		8. BIRTHPLACE (State or Foreign Country) West Virginia	
9a. FACILITY NAME (If not institution, give street and number) 719 Maiden Choice Lane						9b. CITY, TOWN OR LOCATION OF DEATH Catonsville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Catonsville				10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO	
10e. STREET AND NUMBER 719 Maiden Choice Lane						10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 □ YES 2 X NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X NO Specify			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 Civil Engineer			16b. KIND OF BUSINESS/INDUSTRY Army Corp. Of Engineers				
17. FATHER'S NAME (First, Middle, Last) Harper P. Shinn						18. MOTHER'S NAME (First, Middle, Maiden Surname) Metta M. Dean			
19a. INFORMANT'S NAME (Type/Print) Katherine Shinn (Spouse)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 719 Maiden Choice Lane Catonsville, Maryland 21228					
20a. METHOD OF DISPOSITION 1 □ Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery			20c. DATE June 28, 1995		20c. LOCATION — City or Town, State Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Leroy M & Russell C Witzke Funeral Homes 1630 Edmondson Avenue Catonsville Maryland					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →						a. atherosclerotic cerebrovascular disease DUE TO (OR AS A CONSEQUENCE OF):			Approximate Interval Between Onset and Death years
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 □ YES 2 X NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 □ YES 2 X NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 □ Inpatient 2 □ ER/Outpatient 3 □ DOA 4 X Nursing Home 5 □ Residence 6 □ Other (Specify)							
27. MANNER OF DEATH 1 X Natural 5 □ Pending Investigation 2 □ Accident 6 □ Could not be determined 3 □ Suicide 7 □ Determined 4 □ Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 □ YES 2 X NO	28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D44748	29d. DATE SIGNED (Month, Day, Year) ► June 26, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Matthew J. Narrett, M.D. 711 Maiden Choice Lane Catonsville, MD 21228									
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE 							



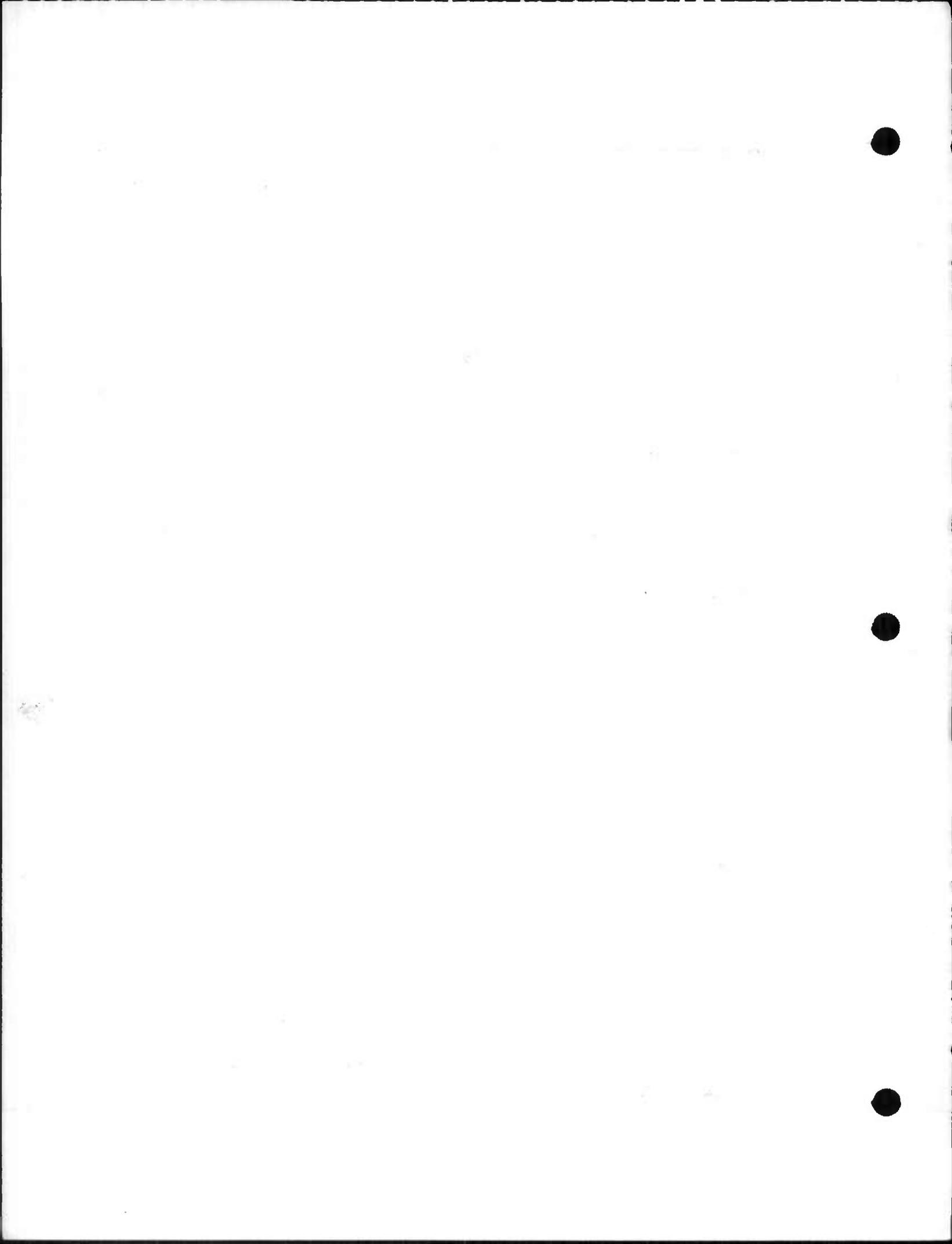
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) Beverly L. Starkes Bevley L. Starkes								2. DATE OF DEATH MONTH DAY YEAR June 22 95	3. TIME OF DEATH 5:15 A.M.
4. SOCIAL SECURITY NUMBER 218-14-9075		5. SEX M	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12/25/21	8. BIRTHPLACE (State or Foreign Country) Virginia
9a. FACILITY NAME (If not institution, give street and number) VA MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH FORT HOWARD				9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEASED									
10a. STATE Maryland	10b. COUNTY n/a	10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
10e. STREET AND NUMBER 3837 CLIFTON AVENUE				10f. ZIP CODE 21216				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		12. WAS DECEASED EVER IN U.S. ARMED FORCES? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> IF YES, GIVE WAR OR DATES 12/8/42 1/2/46			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Cement Finisher			16b. KIND OF BUSINESS/INDUSTRY Gas & Electric Co.				
17. FATHER'S NAME (First, Middle, Last) Lee Stark				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lucy Robinson					
19a. INFORMANT'S NAME (Type/Print) EDITH STARKES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3837 CLIFTON AVENUE BALTIMORE, MD. 21216					
20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet.Cem.			20c. LOCATION — City or Town, State Owings Mills, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY LEROY O. DYETT & SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. PNEUMONIA DUE TO (OR AS A CONSEQUENCE OF): { b. CEREBROVASCULAR ACCIDENT DUE TO (OR AS A CONSEQUENCE OF): c. HYPERTENSION DUE TO (OR AS A CONSEQUENCE OF): d.									
Approximate interval Between Onset and Death 1 DAY									
30 YEARS									
15 YEARS									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <hr/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/>		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D14958							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Aurora Tan, MD		29d. DATE SIGNED (Month, Day, Year) 6/22/95							
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

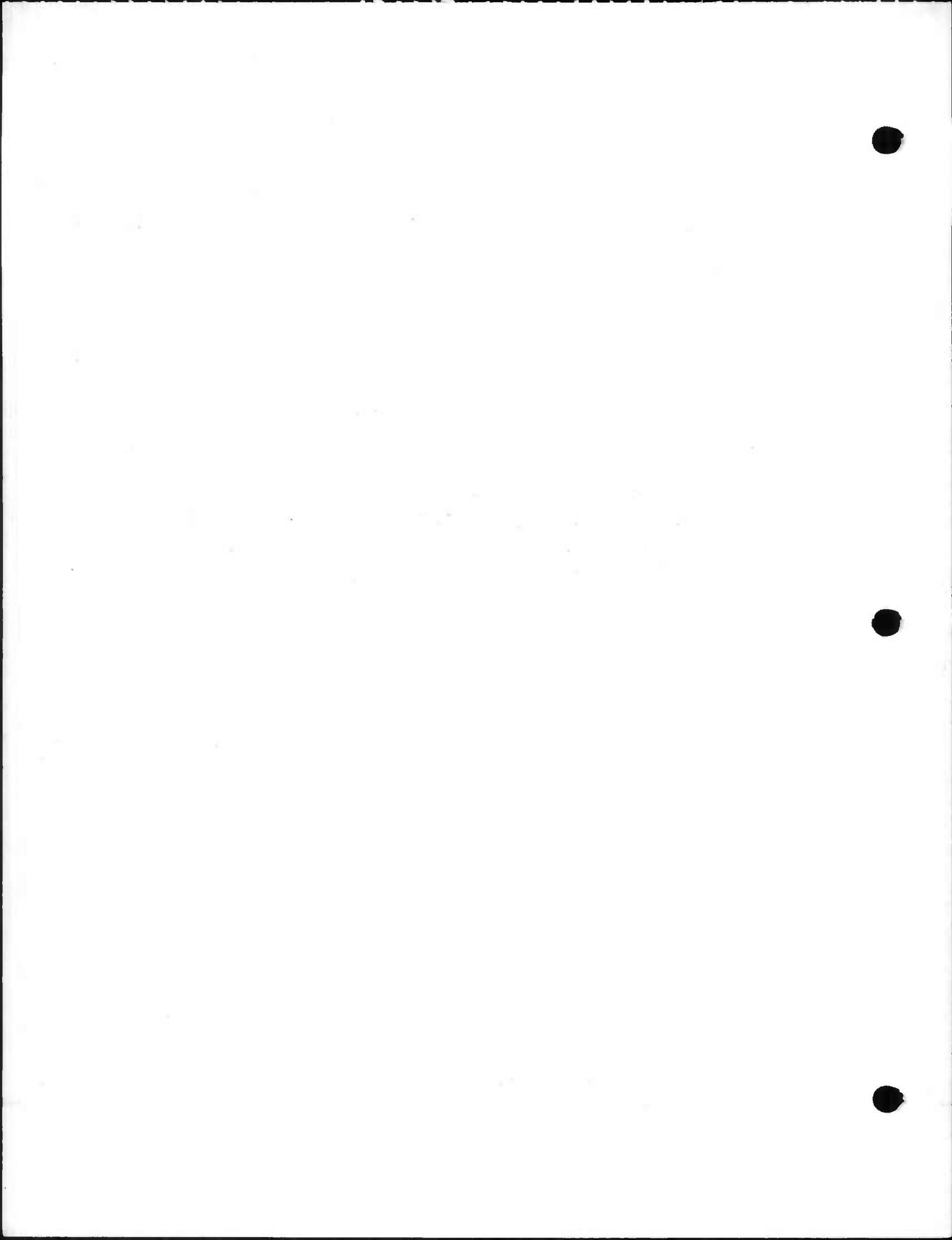
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR JUNE 20 1995										3. TIME OF DEATH 9.20 P M		
1. DECEDENT'S NAME (First, Middle, Last) FEIGA SMOLAR												7. DATE OF BIRTH (Month, Day, Year) NOV. 22, 1909		8. BIRTHPLACE (State or Foreign Country) POLAND
4. SOCIAL SECURITY NUMBER 116-14-7821		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		9. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY		
10e. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 6121 MONTROSE ROAD						10f. ZIP CODE 20852				10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: WHITE		14. RACE — American Indian, Black, White, etc. Specify: WHITE								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)		16b. KIND OF BUSINESS/INDUSTRY ASSISTANT TEACHER		EDUCATION								
17. FATHER'S NAME (First, Middle, Last) LEIBR		18. MOTHER'S NAME (First, Middle, Maiden Surname) LEHRER		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14536 BARKWOOD DRIVE ROCKVILLE, MD 20853										
19e. INFORMANT'S NAME (Type/Print) MRS. NAOMI M. KAPLAN		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, etc., if applicable) BALTIMORE HEBREW		DATE 6-22-1995		20c. LOCATION — City or Town, State REISTERSTOWN, MD								
20e. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)														
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215												
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. (Enter only one cause on each line.)												Approximate Interval Between Onset and Death WEEKS		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. SEPSIS														
DUE TO (OR AS A CONSEQUENCE OF): b. DEMENTIA														
DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CONGESTIVE HEART FAILURE SEIZURE DISORDER												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER P. Talwar, M.D.		29c. LICENSE NUMBER D 36552		29d. DATE SIGNED (Month, Day, Year) JUNE 21 1995										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PANKAJ TALWAR, 6121 MONTROSE RD. ROCKVILLE MD. 20852														
31. DATE FILED (Month, Day, Year) JUN 2 1995		32. REGISTRAR'S SIGNATURE [Signature]												



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

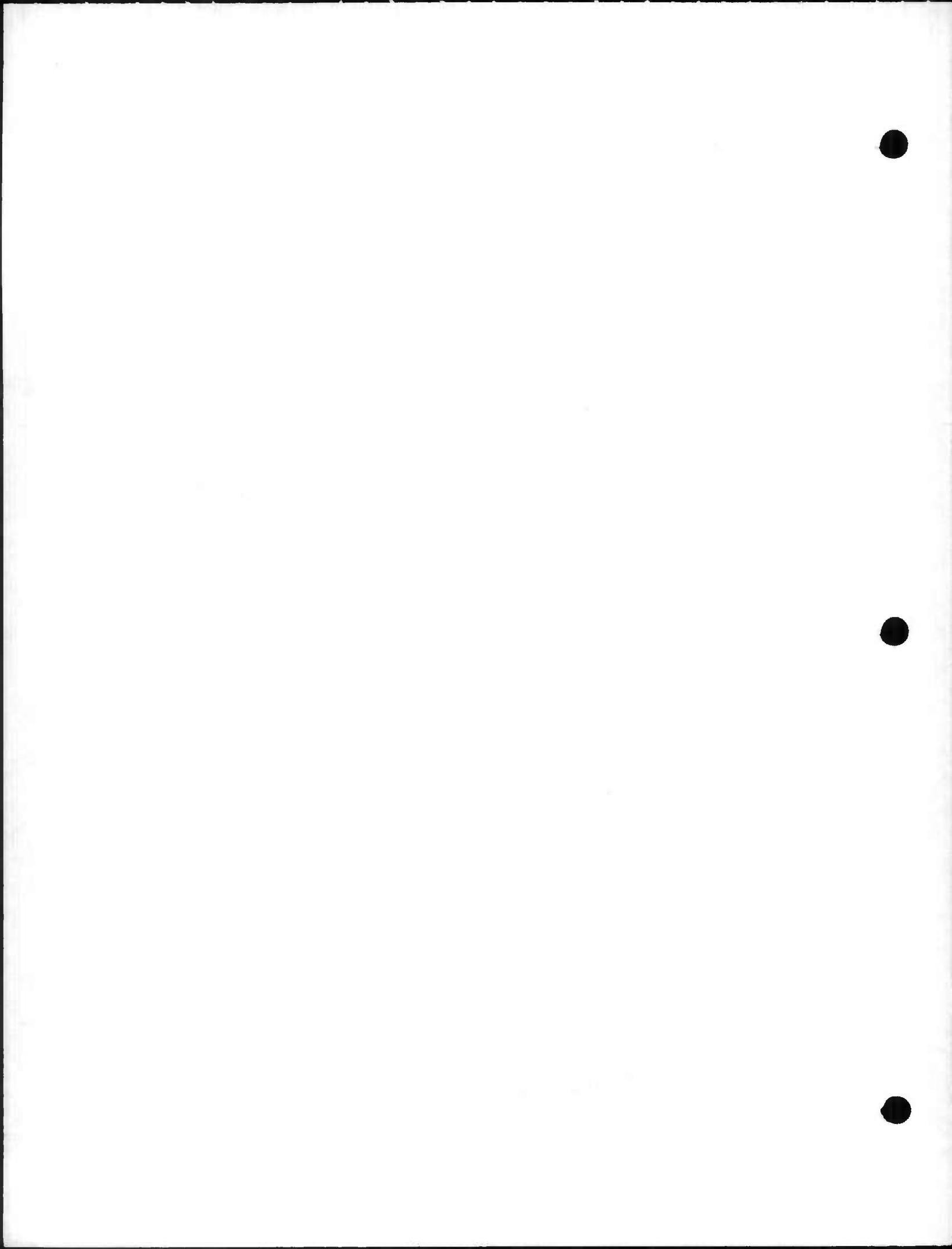
IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR JUNE 23, 1995								3. TIME OF DEATH 16:40	
1. DECEDENT'S NAME (First, Middle, Last) SAMUEL A SPECTOR											
4. SOCIAL SECURITY NUMBER 216-03-8180		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE								9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT											
10a. STATE MD	10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER 725 MT. WILSON LANE				10f. ZIP CODE 21208				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO If YES, GIVE WAR OR DATES X				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: X				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OWNER				16b. KIND OF BUSINESS/INDUSTRY MARY SUE CANDIES					
17. FATHER'S NAME (First, Middle, Last) MORRIS SPECTOR						18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA WAGNER					
19a. INFORMANT'S NAME (Type/Print) LIBBY BERMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 29 RAISIN TREE CIRCLE, BALTIMORE, MD 21208							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) BETH TETLOH				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SOL LEVINSON & BROS., INC.				DATE 6-25-95	20c. LOCATION — City or Town, State BALTIMORE, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → TNEUMONIA											
Approximate Interval Between Onset and Death											
a. DUE TO (OR AS A CONSEQUENCE OF):											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
ATHEROSCLEROTIC CORONARY ARTERIAL DISEASE											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John W. Butler MD</i>		29c. LICENSE NUMBER A52402321589912				29d. DATE SIGNED (Month, Day, Year) June 23, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SINAI HOSPITAL OF BALTIMORE											
31. DATE FILED (Month Day Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>John W. Butler MD</i>									

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DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

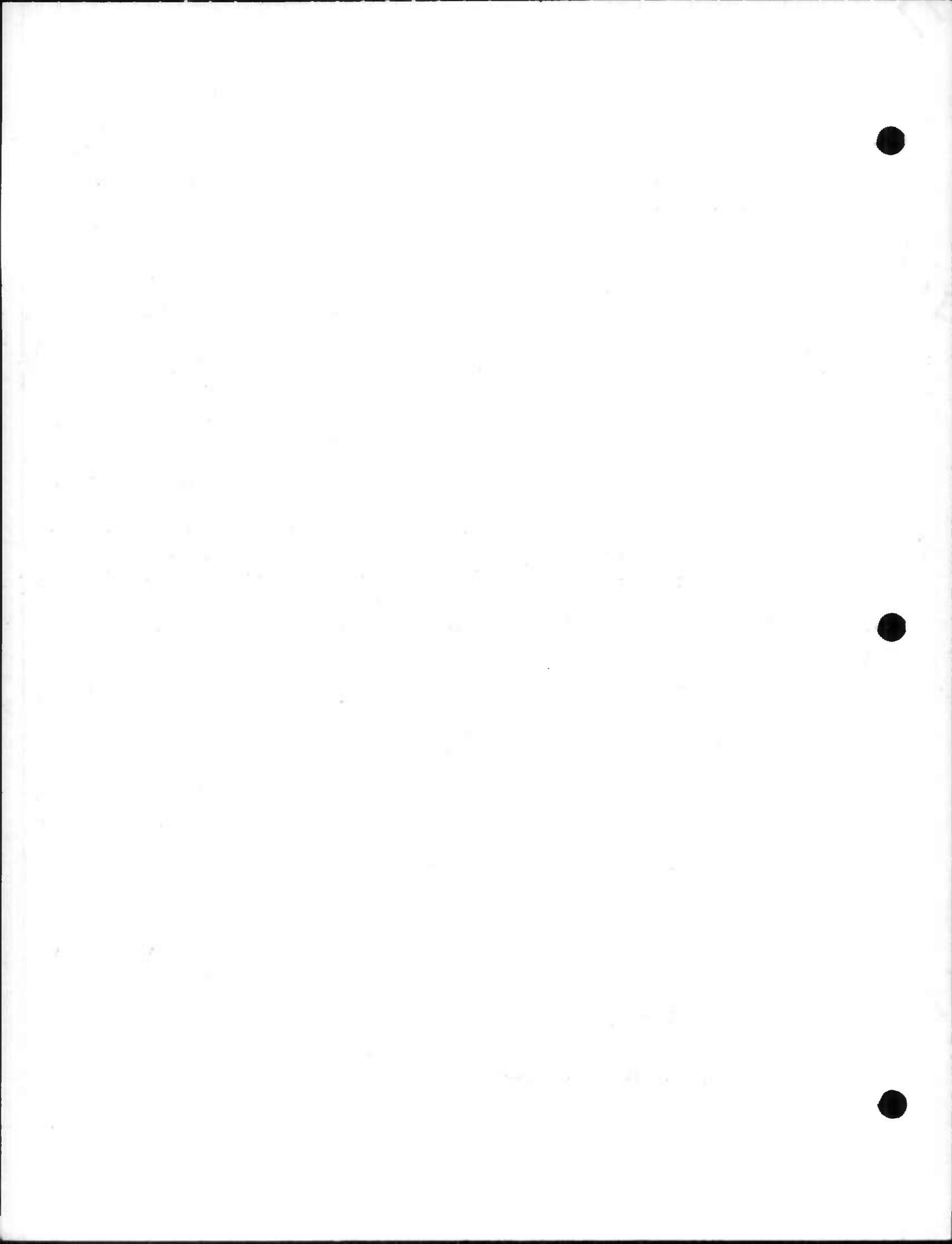
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 8:00 PM	
Hilda Smith											June 24, 1995		
4. SOCIAL SECURITY NUMBER 219-22-8368		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) May 21, 1899	8. BIRTHPLACE (State or Foreign Country) Maryland						
9a. FACILITY NAME (If not institution, give street and number) Wesley Home		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore											
9c. COUNTY OF DEATH Baltimore City													
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Baltimore City	10c. CITY, TOWN OR LOCATION Baltimore										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 2211 W. Rogers Avenue					10f. ZIP CODE 21209					10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home								
17. FATHER'S NAME (First, Middle, Last) Benjamin Condon					18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Dixon								
19a. INFORMANT'S NAME (Type/Print) The Wesley Home					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2211 W. Rogers Avenue, Baltimore, Maryland 21209								
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory					DATE 6/26	20c. LOCATION — City or Town, State Catonsville, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 													
22. NAME AND ADDRESS OF FACILITY Burgee Henss Funeral Home 21211 3631 Falls Road, Baltimore, Maryland													
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Hyper Tension State DUE TO (OR AS A CONSEQUENCE OF):													
b. Dementia DUE TO (OR AS A CONSEQUENCE OF):													
c. Alzheimer's Disease DUE TO (OR AS A CONSEQUENCE OF):													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> 4 <input type="checkbox"/> Homicide <input type="checkbox"/> 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 													
29c. LICENSE NUMBER D21464													
29d. DATE SIGNED (Month, Day, Year) ► 6/25/95													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT LIBERTO, MD, 3508 BARK ST BARTON, MD 21224													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRATION NUMBER John Michael Randall											



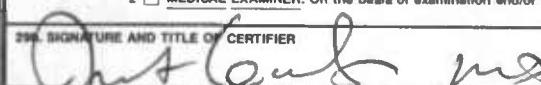
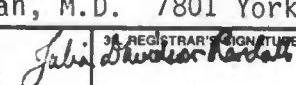
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TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) John P Spain						2. DATE OF DEATH MONTH DAY YEAR June 25 1995	3. TIME OF DEATH 3:04 AM
4. SOCIAL SECURITY NUMBER 321-09-5272		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) 11-1-1908	8. BIRTHPLACE (State or Foreign Country) Illinois	
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH Towson			9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Ruxton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 327 Southwind Rd.			10f. ZIP CODE 21204			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)		16b. KIND OF BUSINESS/INDUSTRY Executive Black and Decker			
17. FATHER'S NAME (First, Middle, Last) Patrick Joseph Spain			18. MOTHER'S NAME (First, Middle, Maiden Surname) Jennie Agnew				
19a. INFORMANT'S NAME (Type/Print) Lillian Spain			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 327 Southwind Rd. Ruxton, Md. 21204				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Bethel Cemetery		DATE 6-27	20c. LOCATION — City or Town, State Seaford, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebrovascular accident, bronchitis</i> Approximate Interval Between Onset and Death <i>3 weeks</i></p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p> <p>{</p> <p>b. <i>ASCVD</i> DUE TO (OR AS A CONSEQUENCE OF): <i>years</i></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D12990					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29d. DATE SIGNED (Month, Day, Year) ► 6/26/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Quinlan, M.D. 7801 York Road Towson, Maryland 21204							
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 					

W. W. Denslow, 1904

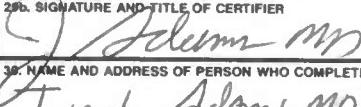
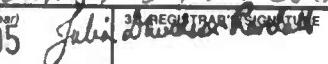
DIVISION OF VITAL RECORDS, P.O. BOX 68760
BALTIMORE, MARYLAND 21215-0020

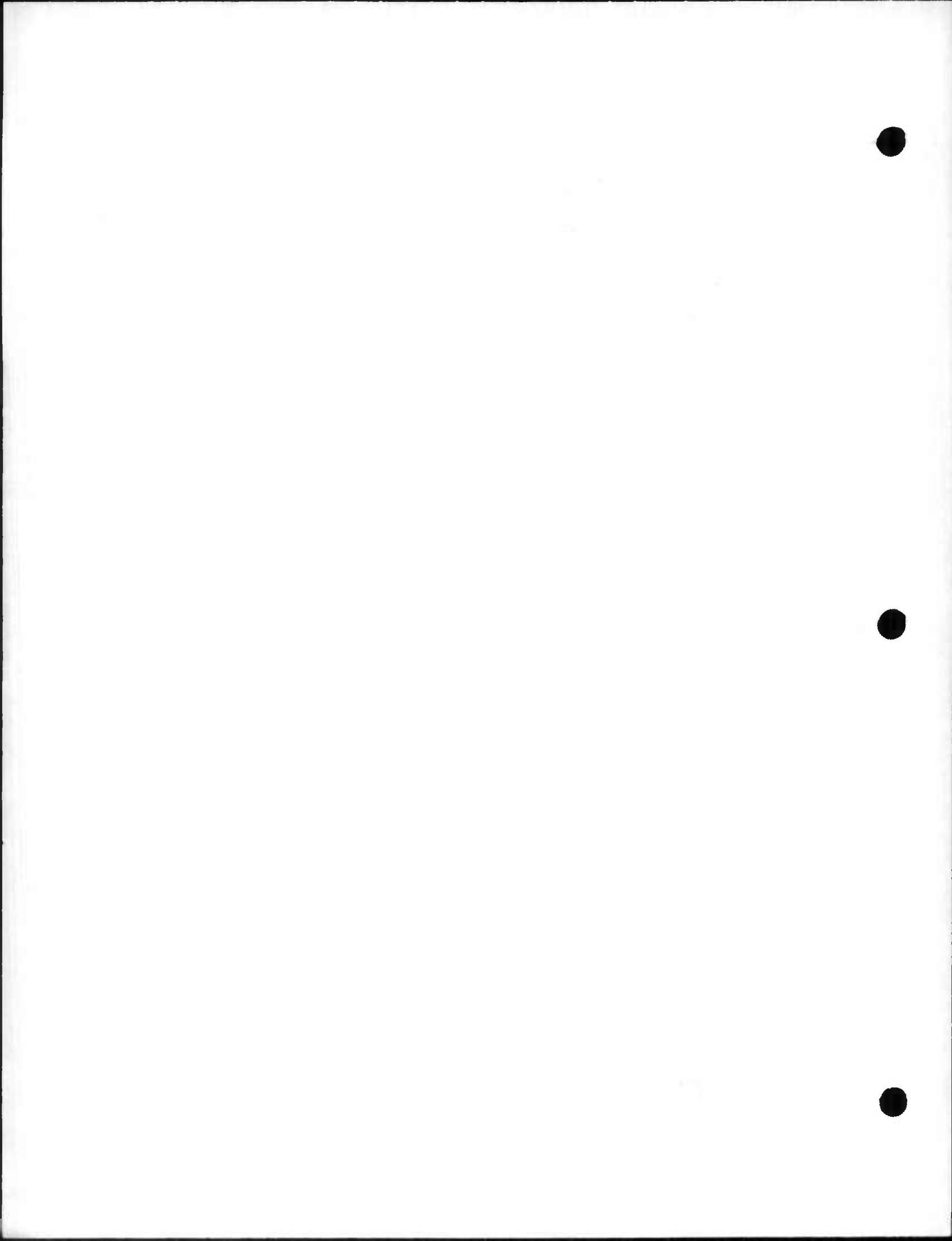
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR												
1. DECEASED'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Clare E. Sears											June 26, 1995	9:40 A M
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.					7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
188-03-1620		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	90 YRS.	MONTHS	DAYS	HOURS	MIN.				Dec. 5 1906	Ohio
9a. FACILITY NAME (If not institution, give street and number)											9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Greater Baltimore Medical Center											Towson	Baltimore
RESIDENCE OF DECEASED												
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
Md.	Baltimore	Towson										
10e. STREET AND NUMBER				10f. ZIP CODE					10g. CITIZEN OF WHAT COUNTRY?			
1055 W. Joppa Rd.				21204					USA			
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+) +4			Sales Manager			Tire Industry				
17. FATHER'S NAME (First, Middle, Last)											18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Court H. Sears											Sara L. Barnarby	
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Erna K. Sears		1055 W. Joppa Rd. Towson Md. 21204										
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Dulaney Valley Cem. 6-30=95 Timonium Md.										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY										
		Ruck Towson F.H. 1050 York Rd. Towson Md. 21204										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. Subdural hematoma												
b. Due to (or as a consequence of): head trauma due to a fall												
c. Due to (or as a consequence of):												
d. Due to (or as a consequence of):												
Approximate Interval Between Onset and Death 1 week 1 week												
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Cormodin for therapy for stroke</i>												
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO												
26. PLACE OF DEATH (Check only one) HOSPITAL: OTHER: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide												
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29f. SIGNATURE AND TITLE OF CERTIFIER 		29g. LICENSE NUMBER D32783			29h. DATE SIGNED (Month, Day, Year) 							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
Joseph Adams MD 7401 Oster Drive Towson, MD 21204												
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE 										



ITEM: 28b, PER MEO FILM G-725 7/10/95 t.t.

ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t.

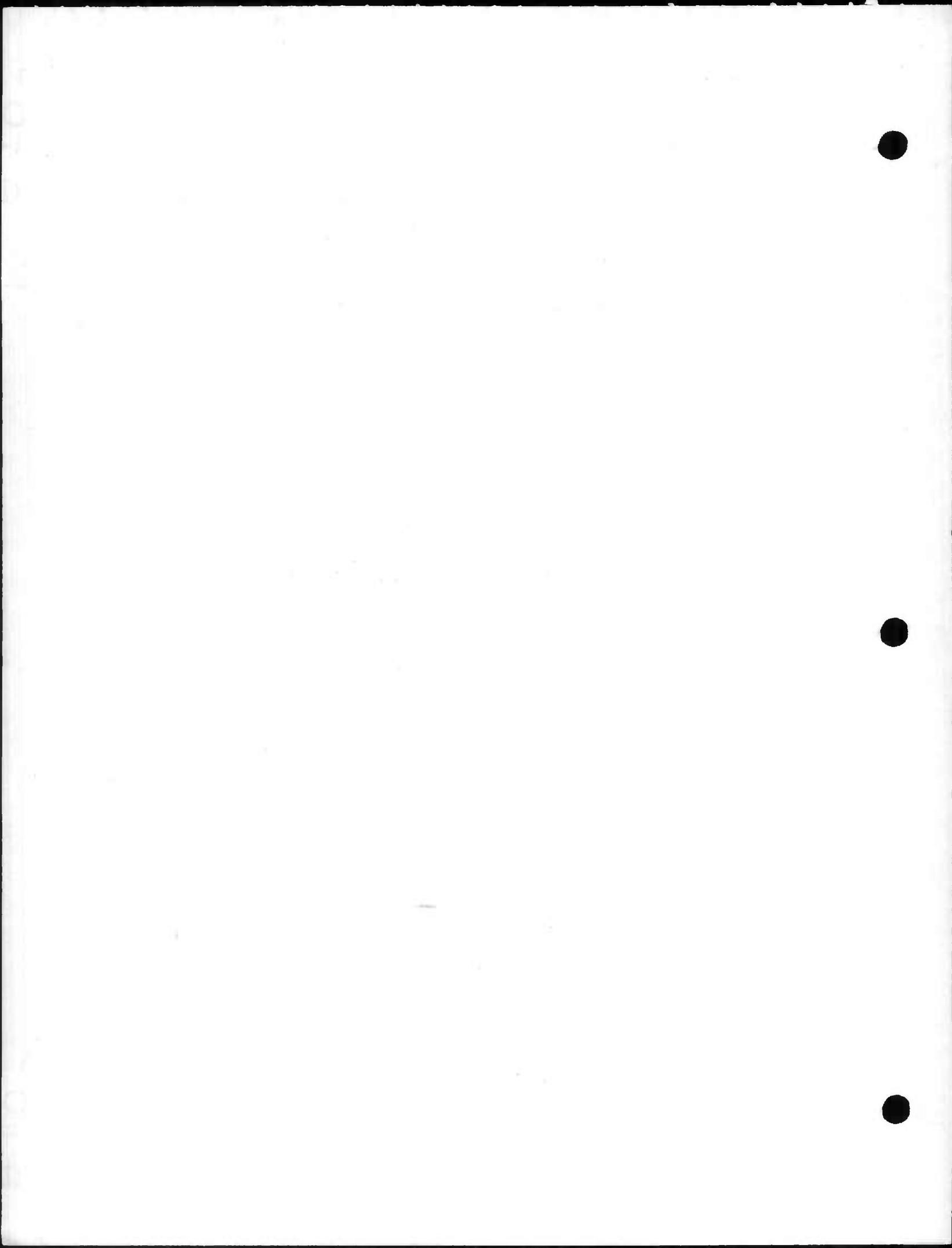
95 19406

FOR
1 - STATE
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH**

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last)		SLOAN				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
MALIKA SLOAN						June 23, 1995	00:44 A M	
4. SOCIAL SECURITY NUMBER 284-72-9209		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 18 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-28-76	8. BIRTHPLACE (State or Foreign Country) OH	
9a. FACILITY NAME (If not institution, give street and number) DOCTORS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH Lanham				9c. COUNTY OF DEATH Prince George		
10e. STATE OH		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION Cincinnati			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 12136 Mason-Montgomery Rd.				10f. ZIP CODE 45249		10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Marketing Rep.			16b. KIND OF BUSINESS/INDUSTRY Sales & Marketing			
17. FATHER'S NAME (First, Middle, Last) James Harris				16. MOTHER'S NAME (First, Middle, Maiden, Surname) Kathryn Harris				
19e. INFORMANT'S NAME (Type/Print) Kathryn C. Sloan				19d. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12136 Mason-Montgomery Rd. Cincinnati, OH 45249				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beech Grove			DATE 6/28	20c. LOCATION — City or Town, State Cincinnati, OH		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James A. Morton</i>				22. NAME AND ADDRESS OF FACILITY James A. Morton & Sons 1701 Laurens St. BALTO., Md. 21217				
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ELECTROCUTION DUE TO (OR AS A CONSEQUENCE OF):								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. _____ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF):								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Inquest 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other		
		28a. DATE OF INJURY (Month, Day, Year) 6-23-95	28b. TIME OF INJURY 12:11 PM	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED ENERGIZED METAL DOOR JAMB			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) AT HOTEL DOOR				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) RD. # RAMADA INN, 8600 ANNAPOLIS NEW CARROLLTON, P.G. COUNTY, MD.		
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann Dixon</i>		
						29c. LICENSE NUMBER OCME	29d. DATE SIGNED (Month, Day, Year) ► JUNE 24, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) ANN DIXON		31. DATE FILED (Month, Day, Year) JUN 27 1995						



DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

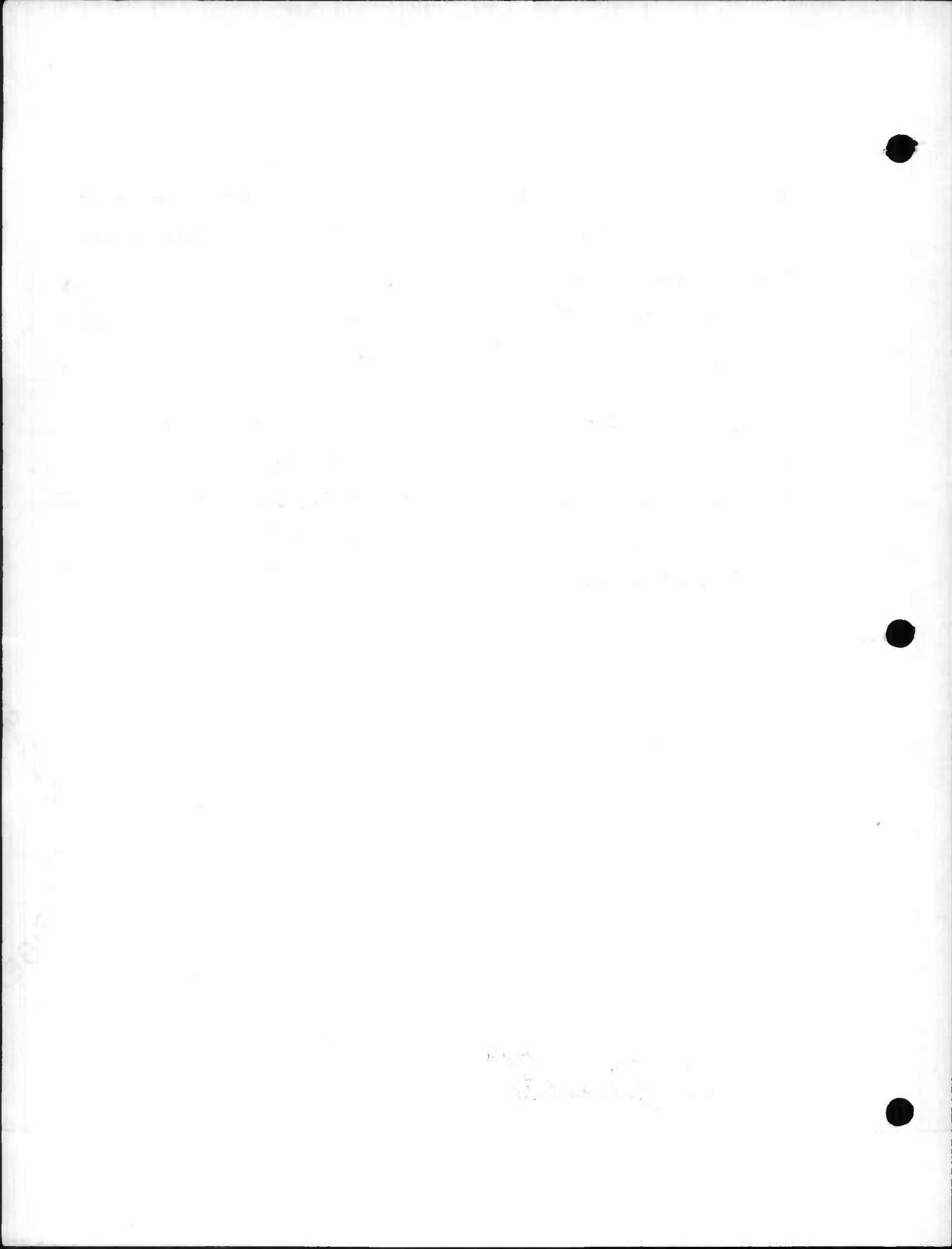
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) RACHELLE SELZER										2. DATE OF DEATH MONTH 06 DAY 23 YEAR 1995	3. TIME OF DEATH 11:30 PM
4. SOCIAL SECURITY NUMBER 563 44 6231		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	7. DATE OF BIRTH (Month, Day, Year) 11-04-1925		8. BIRTHPLACE (State or Foreign Country) ROMANIA			
9a. FACILITY NAME (If not institution, give street and number) Manor Care Fernwood					9b. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY				
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 10524 WEYMOUTH St. #203					10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) THERAPIST			16b. KIND OF BUSINESS/INDUSTRY MENTAL HEALTH						
17. FATHER'S NAME (First, Middle, Last) RUBIN ZELZER					16. MOTHER'S NAME (First, Middle, Maiden Surname) (UNKNOWN)						
18a. INFORMANT'S NAME (Type/Print) PAUL R. MANDELBAUM					18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 362 BRYANT AVE #3: CINCINNATI OH 45220						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE WASHINGTON CEMETERY 424/95 LAUREL, MD			20c. DATE 424/95		20c. LOCATION — City or Town, State LAUREL, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sylvia Dohmann</i>		22. NAME AND ADDRESS OF FACILITY CAFA STEPHEN & LOHRENNAN P.A. 21286 8717 GREEN PASTURES DR. BALTIMORE MD									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 10 days	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular Accident - Ischemic Infarct DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. _____ b. _____ c. _____ d. _____ DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Coronary Artery Disease										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jeffrey Drosos MD</i>		29c. LICENSE NUMBER D18137			29d. DATE SIGNED (Month, Day, Year) 6/24/95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JEFFREY DROSOS MD 10810 CONNECTICUT AVE KENSINGTON MD 20855											
31. DATE FILLED (Month, Day, Year) JUN 27 1995		RECEIVED BY <i>Jahn</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

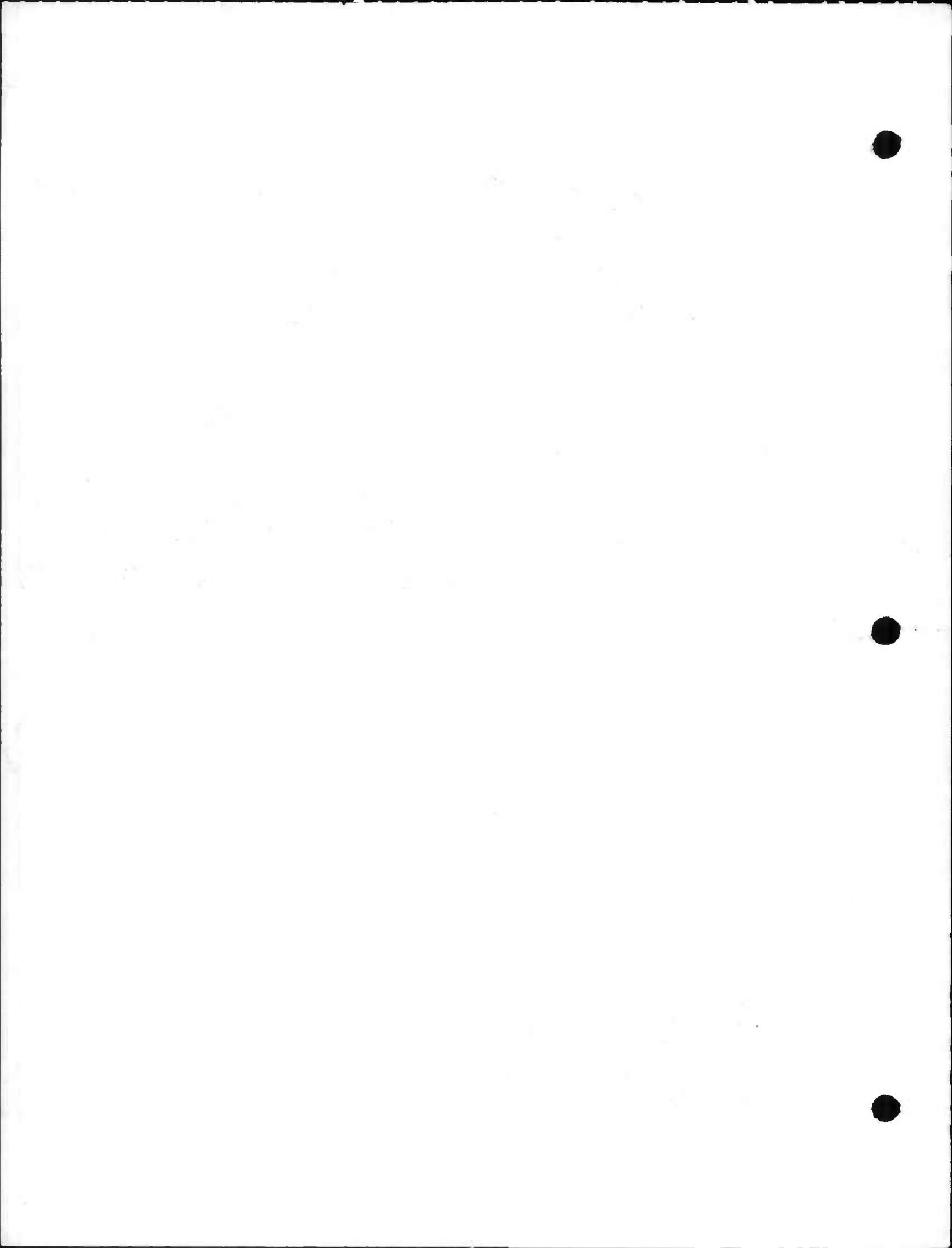
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last) MARGARET STITH												2. DATE OF DEATH MONTH JUNE DAY 24 , 1995 YEAR 1995	3. TIME OF DEATH 08:50 A.M.			
4. SOCIAL SECURITY NUMBER 212-22-2166			5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 83 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH Month, Day, Year March 9, 1912			8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Liberty Medical Center			9b. CITY, TOWN OR LOCATION OF DEATH Balto.		9c. COUNTY OF DEATH N/A											
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 1907 Bentlou St.						10f. ZIP CODE 21216			10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:						14. RACE — American Indian, Black, White, etc. Specify: Black						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic			16b. KIND OF BUSINESS/INDUSTRY Outside Home										
17. FATHER'S NAME (First, Middle, Last) Morris Blake.			18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary E. Harris													
19a. INFORMANT'S NAME (Type/Print) Beatrice Smith			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3018 Brighton St. Balto, Md. 21216													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery, or other place) New Cathedral Cemetery			DATE 6/29/95			20c. LOCATION — City or Town, State Balto, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Joseph L. Russ			22. NAME AND ADDRESS OF FACILITY Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216													
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death				
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Hypovolemia DUE TO (OR AS A CONSEQUENCE OF): b. Anemia DUE TO (OR AS A CONSEQUENCE OF): c. Gastrointestinal bleeding DUE TO (OR AS A CONSEQUENCE OF): d.												24 hrs.				
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												48 hrs.				
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Atrial fibrillation with rapid Ventricular response Atherosclerotic cardiovascular disease												48 hrs.				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA			OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
												28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. SIGNATURE AND TITLE OF CERTIFIER H. Culver, MD		House officer						29c. LICENSE NUMBER D45148			29d. DATE SIGNED (Month, Day, Year) ► 6-24-95					
29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (If not same as above) Ricardo Osorio, MD, LIBERTY MEDICAL CENTER 2600 Liberty Heights Ave., Baltimore, MD 21215																
31. DATE FILED (Month, Day, Year) JUN 27 1995																



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

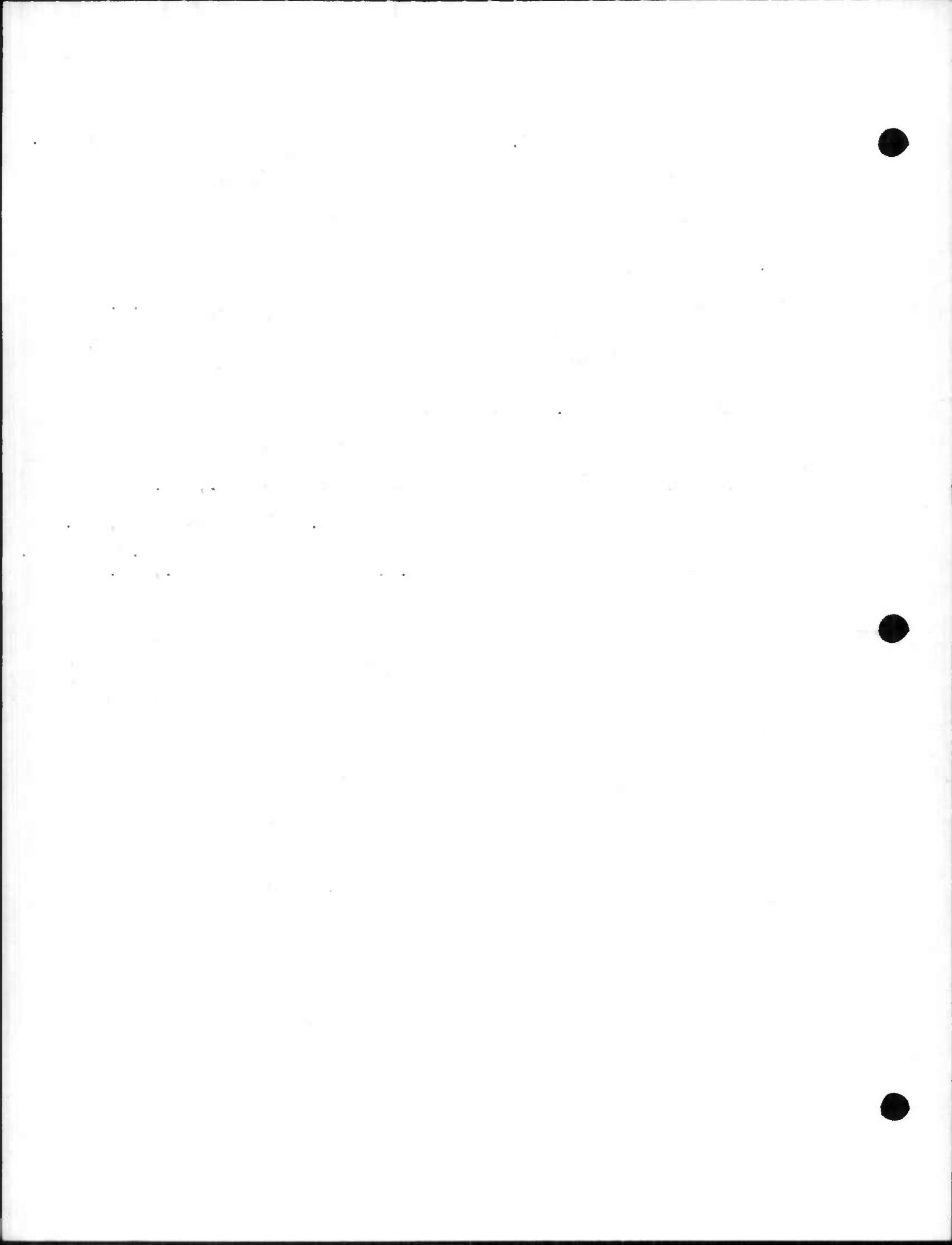
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19409

TO BE COMPLETED BY FUNERAL DIRECTOR		DECEASED'S INFORMATION									
		1. DECEASED'S NAME (First, Middle, Last)		Keith K. Smith				2. DATE OF DEATH MONTH JUNE DAY 22 YEAR 95		3. TIME OF DEATH 5:40 A.M.	
		4. SOCIAL SECURITY NUMBER 218-64-1776		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 35 YRS.		IF UNDER 1 YEAR MONTHS 0 DAYS HOURS 0 MIN. 0		7. DATE OF BIRTH Month, Day, Year 08-10-58	
		9a. FACILITY NAME (If not institution, give street and number) 4716 Wilern Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH N/A		8. BIRTHPLACE (State or Foreign Country) Maryland	
		RESIDENCE OF DECEASED									
		10a. STATE MD.	10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
		10e. STREET AND NUMBER 4716 Wilern Avenue		10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? U.S.			
		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 9/77--9/83 Army		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black	
		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2yrs.		16b. KIND OF BUSINESS/INDUSTRY Computer Programmer Computer					
		17. FATHER'S NAME (First, Middle, Last) Lee Clark		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Smith							
		19a. INFORMANT'S NAME (Type/Print) Mary Tanner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4716 Wilern Avenue Balto., MD. 21215							
		20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest Vet. 6/27		DATE		20c. LOCATION — City or Town, State Owings Mills, MD.			
		21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Dorothy Clark CFSP #281		22. NAME AND ADDRESS OF FACILITY 1721-27 N. Monroe St. E.L. Phillips F/H Balto., MD. 21217							
		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
		<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. Encephalopathy DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. Retroviral Infection DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. _____ DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p>									
		Approximate Interval Between Onset and Death 6 months 10 years									
		PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CMV Retinitis.									
		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
		29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D38398				29d. DATE SIGNED (Month, Day, Year) ► 6-26-95			
		2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29e. SIGNATURE AND TITLE OF CERTIFIER Joe E. Gallant, MD							
		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joe E. Gallant, MD 600 N. Wolfe St, Carnegie 292,		32. REGISTRAR'S SIGNATURE July 27 1995							
		31. DATE FILED (Month, Day, Year) JUN 27 1995									



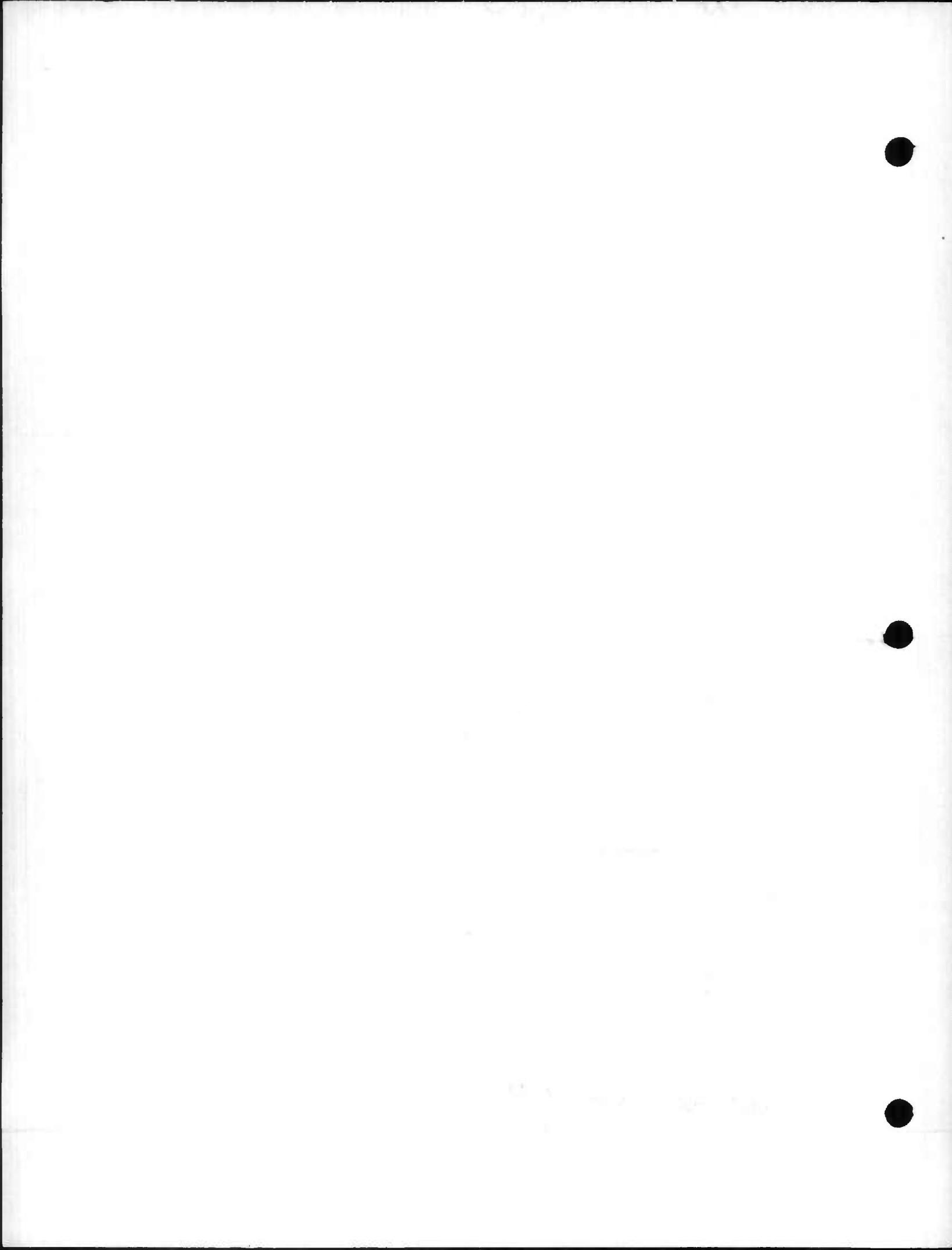
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.													
1. DECEASED'S NAME (First, Middle, Last) <i>Lena Agnes Thomann</i>						2. DATE OF DEATH MONTH DAY YEAR <i>June 26 1995</i>	3. TIME OF DEATH 10:15 A.M.												
4. SOCIAL SECURITY NUMBER <i>217-38-1166</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>95</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) <i>Dec. 24, 1899</i>	8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>												
9a. FACILITY NAME (If not institution, give street and number) <i>701 Maiden Choice Lane</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Catonsville</i>	9c. COUNTY OF DEATH <i>Baltimore</i>												
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Baltimore</i>	10c. CITY, TOWN OR LOCATION <i>Catonsville</i>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO													
10e. STREET AND NUMBER <i>701 Maiden Choice Lane</i>				10f. ZIP CODE <i>21228</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>													
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>													
15. DECEASED'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>College (1-4 or 5+)</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Homemaker</i>		16c. LOCATION — City or Town, State <i>Own Home</i>													
17. FATHER'S NAME (First, Middle, Last) <i>John List</i>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Heinricha Herpic</i>													
19a. INFORMANT'S NAME (Type/Print) <i>Richard Draper</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>15115 Interlachen Drive Silver Spring, Maryland 20906</i>															
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park Cemetery</i>		20c. DATE <i>June 29, 1995</i>		20c. LOCATION — City or Town, State <i>Baltimore, Maryland</i>													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M & Russell C Witzke Funeral Homes</i>				22. NAME AND ADDRESS OF FACILITY <i>1630 Edmondson Avenue Catonsville Maryland</i>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST																			
<table border="0"> <tr> <td>a.</td> <td><i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):</td> <td>Approximate interval Between Onset and Death <i>DAYS</i></td> </tr> <tr> <td>b.</td> <td><i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):</td> <td>YEARS</td> </tr> <tr> <td>c.</td> <td><i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):</td> <td>YEARS</td> </tr> <tr> <td>d.</td> <td></td> <td></td> </tr> </table>								a.	<i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):	Approximate interval Between Onset and Death <i>DAYS</i>	b.	<i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):	YEARS	c.	<i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):	YEARS	d.		
a.	<i>Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):	Approximate interval Between Onset and Death <i>DAYS</i>																	
b.	<i>Coronary Artery Disease</i> DUE TO (OR AS A CONSEQUENCE OF):	YEARS																	
c.	<i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):	YEARS																	
d.																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sick Sinus Syndrome</i> <i>Atrial Fibrillation</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO												
25. HAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26c. OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <table border="0"><tr><td><input checked="" type="checkbox"/> Natural</td><td><input type="checkbox"/> Pending investigation</td></tr><tr><td><input type="checkbox"/> Accident</td><td></td></tr><tr><td><input type="checkbox"/> Suicide</td><td></td></tr><tr><td><input type="checkbox"/> Homicide</td><td><input type="checkbox"/> Could not be determined</td></tr></table>		<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide		<input type="checkbox"/> Homicide	<input type="checkbox"/> Could not be determined	28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																		
<input type="checkbox"/> Accident																			
<input type="checkbox"/> Suicide																			
<input type="checkbox"/> Homicide	<input type="checkbox"/> Could not be determined																		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)																
29a. SIGNATURE AND TITLE OF CERTIFIER <i>Matthew J. Narrett M.D.</i>		29c. LICENSE NUMBER <i>D44748</i>		29d. DATE SIGNED (Month, Day, Year) <i>► June 26, 1995</i>															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Matthew J. Narrett M.D. 701 Maiden Choice Lane Catonsville, MD</i>																			
31. DATE FILED (Month, Day, Year) <i>JUN 21 1995</i>		32. REGISTRAR'S SIGNATURE <i>Jahn Shuler Reiter</i>																	



95 19411

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

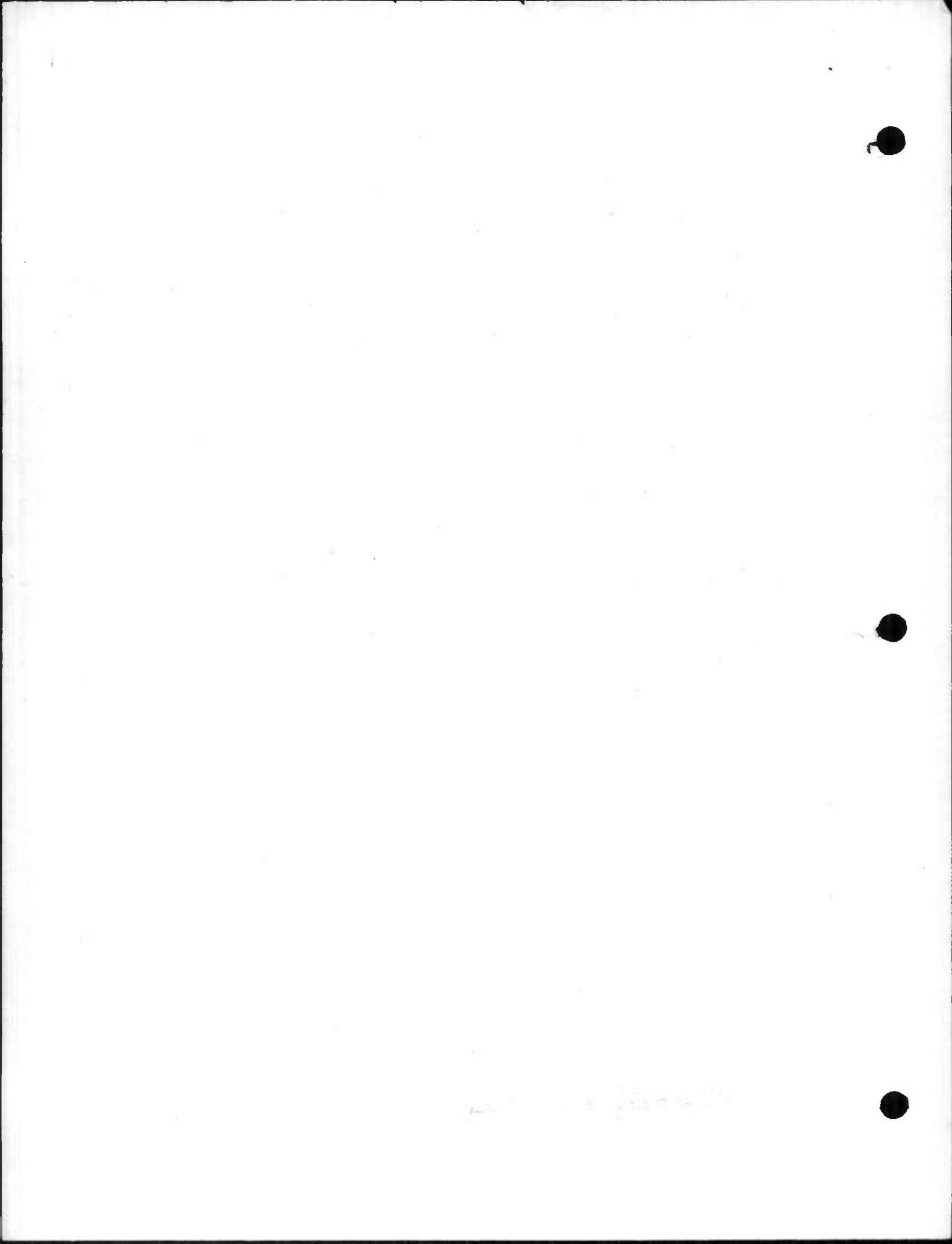
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) MICHAEL S. TIMMINS										2. DATE OF DEATH MONTH JUNE DAY 24 YEAR 1995	3. TIME OF DEATH 5:57 AM
4. SOCIAL SECURITY NUMBER 215-86-0412		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 33 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 6/14/62			8. BIRTHPLACE (State or Foreign Country) MD.
9a. FACILITY NAME (If not institution, give street and number) 3803 S. HANOVER STREET										9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	9c. COUNTY OF DEATH
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 3803 S. Hanover St.						10f. ZIP CODE 21225		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Mechanic			16b. KIND OF BUSINESS/INDUSTRY City of Baltimore					
17. FATHER'S NAME (First, Middle, Last) Francis S. Timmins						18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Schultz					
19a. INFORMANT'S NAME (Type/Print) Mrs. Susan E. Timmins						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3803 S. Hanover St. Baltimore, Md. 21225					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Mem. Park				DATE 6/28/95	20c. LOCATION — City or Town, State Dorsey, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Eugen L. Latson						22. NAME AND ADDRESS OF FACILITY McCullly Funeral Home of Brooklyn 237 E. Patapsco Ave. Balto., Md. 21225					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Atherosclerotic cardiovascular disease										Approximate Interval Between Onset and Death	
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Undetermined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29c. LICENSE NUMBER O.C.M.E.			29d. DATE SIGNED (Month, Day, Year) JUNE 24, 1995
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) David R. Fowler										31. DATE FILED (Month, Day, Year) JUN 27 1995	
										32. REGISTRAR'S SIGNATURE Juliann Roberts	

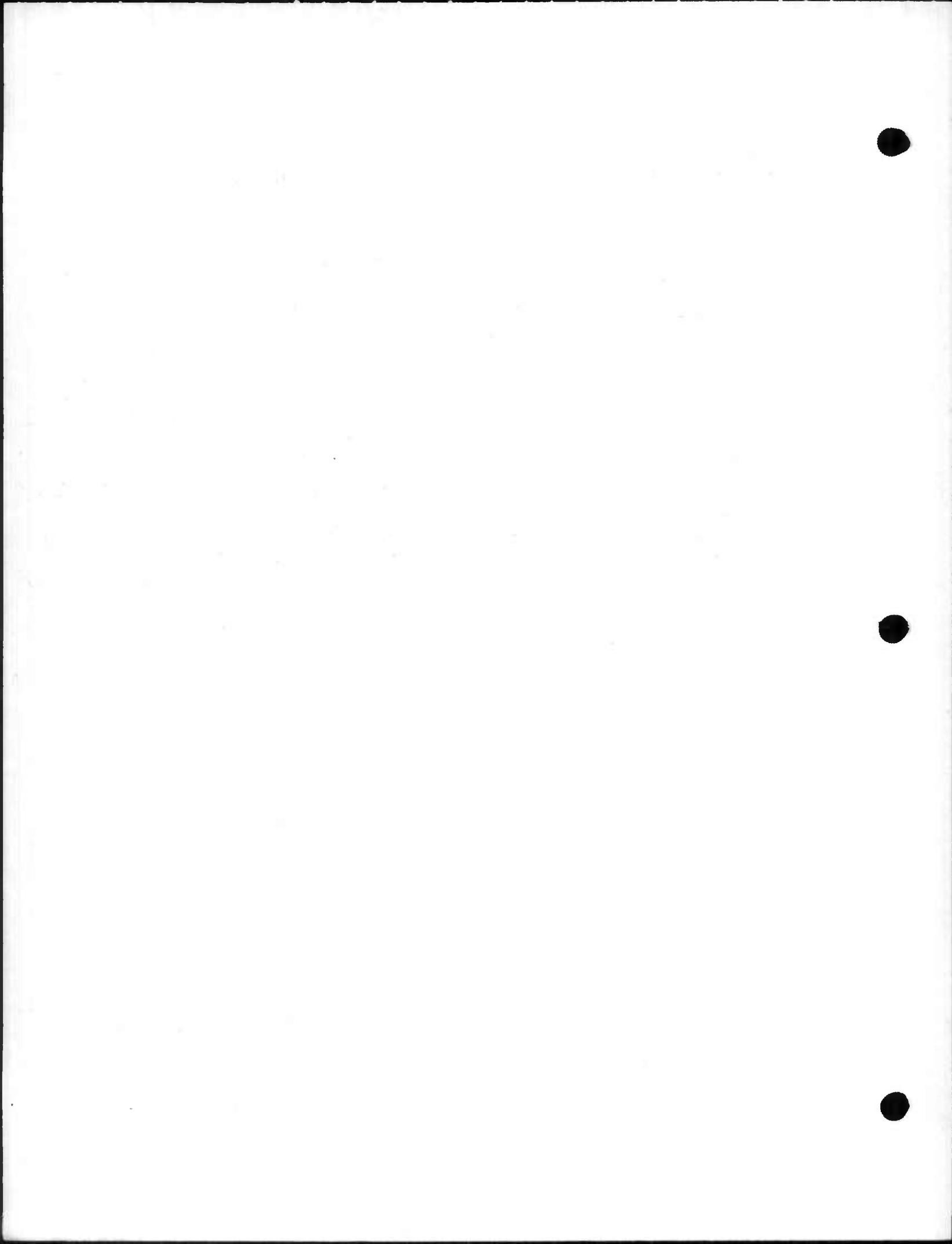


95 19412

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EARLEAN THOMAS				2. DATE OF DEATH MONTH DAY YEAR 6 24 1995	3. TIME OF DEATH 9:37 a.m.		
4. SOCIAL SECURITY NUMBER 227-1B-9574		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) MAR 21 1924	8. BIRTHPLACE (State or Foreign Country) N.C. CAROLINA	
9a. FACILITY NAME (If not institution, give street and number) HARBOR HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A	
RESIDENCE OF DECEDENT							
10a. STATE MD	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION GLEN BURNIE				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 186 MORRIS HILL Ave.				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? U.S.A	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TEACHER		16b. KIND OF BUSINESS/INDUSTRY BALT. CITY SCHOOL			
17. FATHER'S NAME (First, Middle, Last) EARL Thomas				18. MOTHER'S NAME (First, Middle, Maiden Surname) RACHEL FERGUSON			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 186 MORRIS HILL Ave. Glen Burnie MD 21060			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) METROPOLITAN CEMETERY 46th & BALTIMORE MD.		20c. LOCATION — City or Town, State CAROLYN MARCH FUNERAL HOME P.O. 2771 FRED HILL TOWNSHIP BALTIMORE MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						Approximate Interval Between Onset and Death	
24. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH X Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER O.C.M.E				29d. DATE SIGNED (Month, Day, Year) JUN. 27, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ANN DIXON 111 PENN ST. BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>John Shadwell Hartell</i>				DHMH-16 Rev 1/99	



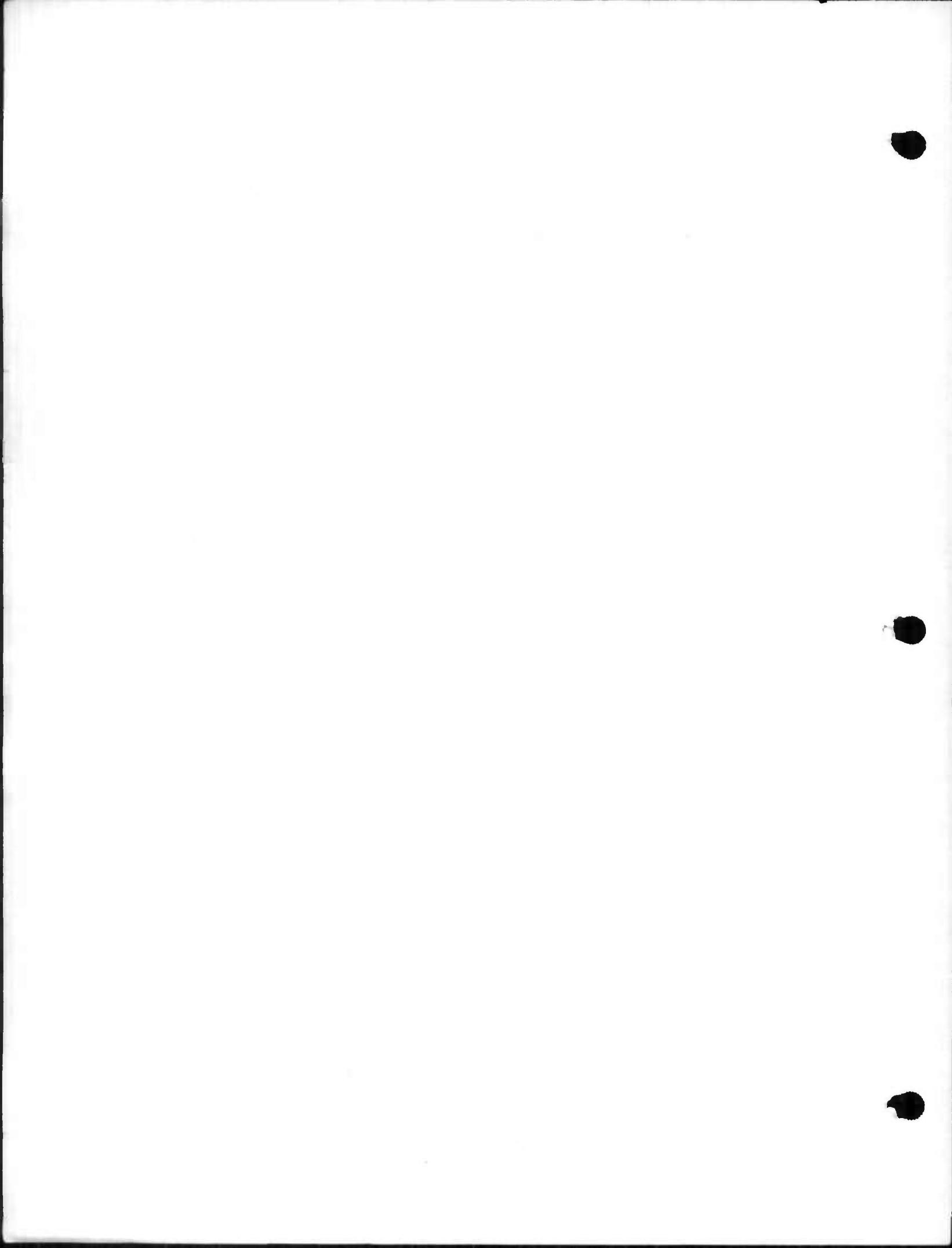
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.						
1. FOR STATE REGISTRAR																
2. DATE OF DEATH MONTH DAY YEAR 6 23 1995											3. TIME OF DEATH 9:15 PM					
4. SOCIAL SECURITY NUMBER 220-22-7273											5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (in yrs. last birthday) 91 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 4/14/1904	8. BIRTHPLACE (State or Foreign Country) VA
9a. FACILITY NAME (If not institution, give street and number) Pleasant Manor Nursing Center											9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH n/a			
10a. STATE Maryland		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Baltimore						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
10e. STREET AND NUMBER 4615 Park Heights Avenue				10f. ZIP CODE 21215				10g. CITIZEN OF WHAT COUNTRY? U.S.A.								
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) — Homemaker			16b. KIND OF BUSINESS/INDUSTRY in own home											
17. FATHER'S NAME (First, Middle, Last) Sam Watkins					18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie											
19a. INFORMANT'S NAME (Type/Print) Doris Copeland				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1764 Homestead Street/Baltimore, Maryland 21218												
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery 4-27-95				20c. LOCATION — CITY or Town, State Catonsville, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bernard D Johnson</i>				22. NAME AND ADDRESS OF FACILITY March Funeral Home-East 1101 E. North Avenue/Baltimore, Maryland				21202								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral Thrombosis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Arteriosclerotic Heart Disease - Arterio fibrillation 6 years</i>											Approximate Interval Between Onset and Death <i>1 day</i>					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Central Thromboses & Hemorrhages</i> <i>Multifocal dementia with seizures</i> <i>Dysphagia with swallowary feeding</i>																
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED								
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)														
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Manuel Levin M.D.</i>		29c. LICENSE NUMBER 005622		29d. DATE SIGNED (Month, Day, Year) <i>6/24/95</i>										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Manuel Levin, M.D., 6101 Park Heights Ave., Baltimore, MD 21215																
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Jeanne Schreiber</i>														
DNMN-18 Rev 1/89																



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

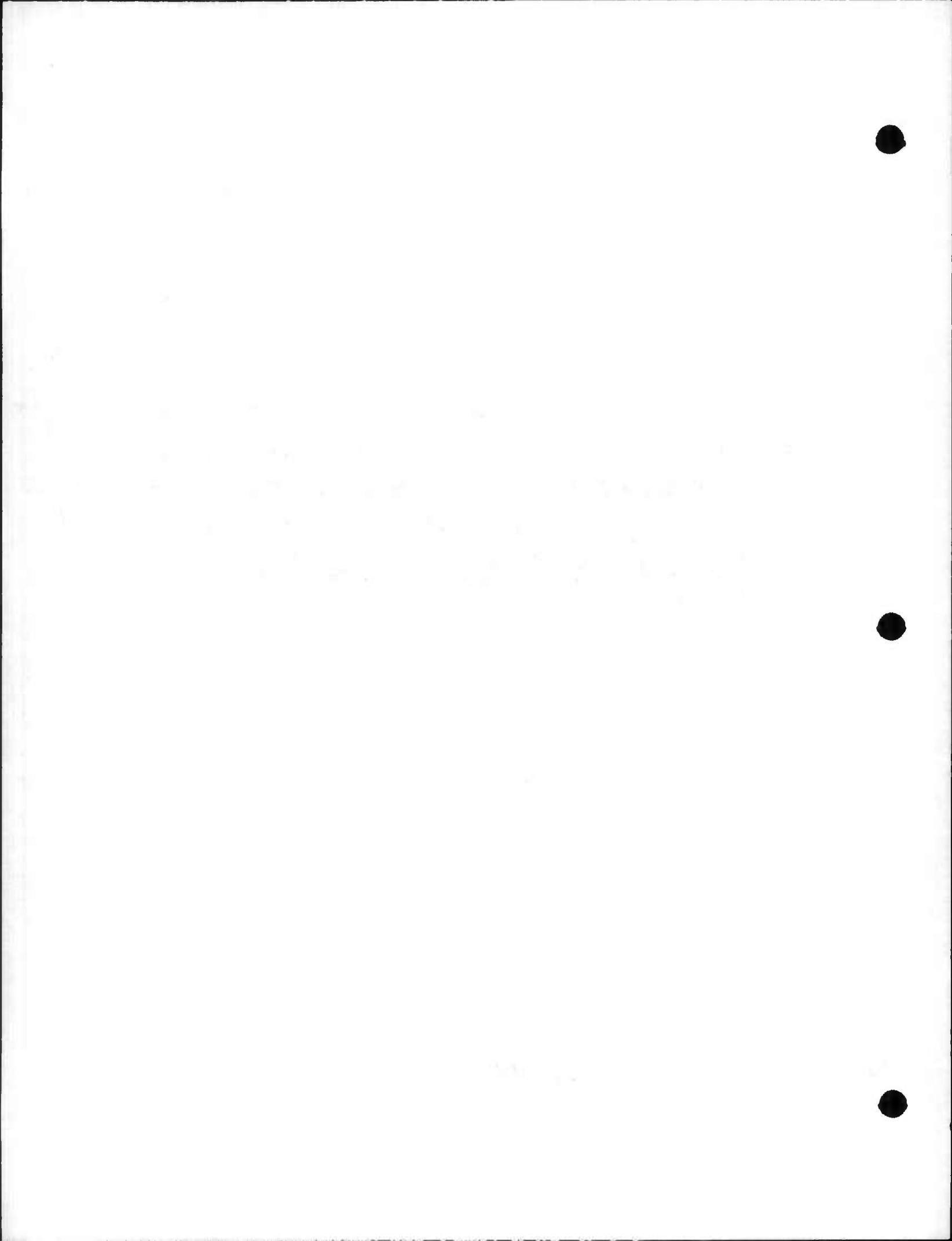
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR						3. TIME OF DEATH						
<u>JANIE THOMAS</u>		6 23 95						5:45 P M						
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12/11/17		8. BIRTHPLACE (State or Foreign Country) South Carolina		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH						
<u>Bon Secours Hospital Baltimore</u>								N/A						
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
<u>Maryland</u>		<u>N/A</u>		<u>Baltimore</u>										
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?						
<u>2825 W. Lafayette Ave.</u>		<u>21216</u>						<u>USA</u>						
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES						13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <u>Black</u>						
14. RACE — American Indian, Black, White, etc. Specify: <u>Black</u>														
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)						16b. KIHO OF BUSINESS/INDUSTRY						
<u>Elementary/Secondary (0-12)</u>		<u>School</u>						<u>Teacher Education</u>						
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)												
<u>Patterson Anthony</u>		<u>Maggie Anthony</u>												
19a. INFORMANT'S NAME (Type or Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
<u>Sandra Brockington</u>		<u>Arbutus 42895</u>						<u>Balto. Co. Md.</u>						
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)						20c. LOCATION — City or Town, State						
<input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u></u>														
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY												
<u>Joseph L. Russ</u>		<u>Joseph L. Russ Funeral Home</u>												
23. PART I: Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death						
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<u>MYOCARDIAL INFARCTION</u>						<u>~21 hours</u>						
		DUE TO (OR AS A CONSEQUENCE OF):												
		<u>Coronary Artery Disease</u>						<u>~10 years</u>						
		DUE TO (OR AS A CONSEQUENCE OF):												
		DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		<u>DIABETES MELLUS, HYPERTENSION, RENAL INSUFFICIENCY</u>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		<u>HOSPITAL: <input checked="" type="checkbox"/></u> OTHER: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u></u>												
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED			
<input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide														
29a. CERTIFIER (Check only one)		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
<input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
<input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Carol Ann Huff M.D.</u>		29c. LICENSE NUMBER <u>L4718</u>						29d. DATE SIGNED (Month, Day, Year) <u>JUNE 27, 1995</u>						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)														
<u>Carol Ann Huff M.D.</u>		<u>600 North Wolfe Street</u>						<u>Baltimore 21287</u>						
31. DATE FILED (Month, Day, Year)														
<u>JUN 27 1995</u>														



DIVISION OF VITAL RECORDS, P.O. BOX 68760
BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

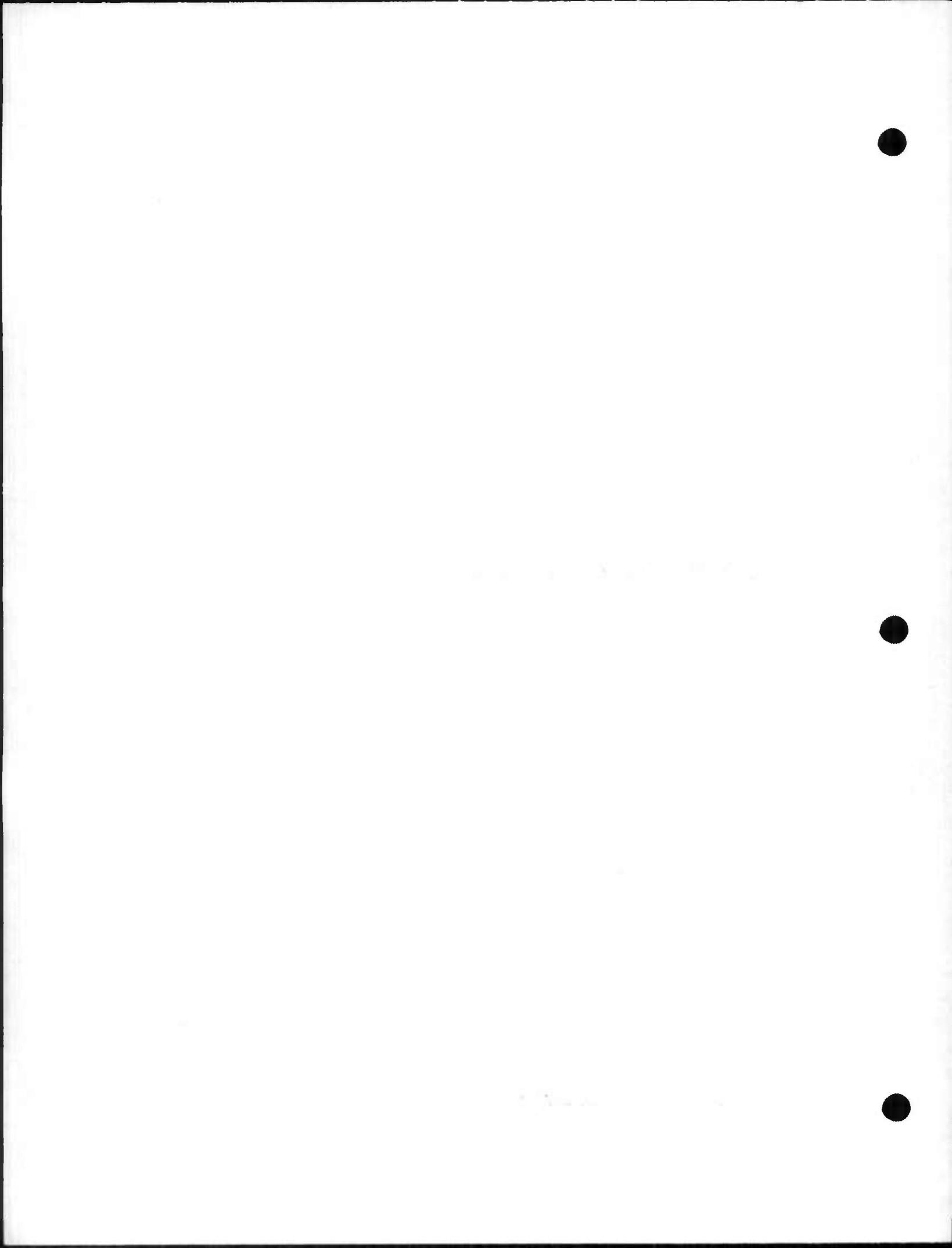
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19415

1. DECEDENT'S NAME (First, Middle, Last) WILLIAM WOODARD						2. DATE OF DEATH MONTH DAY YEAR July 20 1995	3. TIME OF DEATH 1630 M
4. SOCIAL SECURITY NUMBER 259-28-4476		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 	IF UNDER 24 HRS. 	7. DATE OF BIRTH (Month, Day, Year) Mar. 10, 1899	8. BIRTHPLACE (State or Foreign Country) Georgia
9a. FACILITY NAME (If not institution, give street and number) Union Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Cecil	10c. CITY, TOWN OR LOCATION Elkton				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER Laurelwood Nursing Ctr PO Box 1444			10f. ZIP CODE 21921			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: 		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3rd		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Laborer		16b. KIND OF BUSINESS/INDUSTRY Roofing Business			
17. FATHER'S NAME (First, Middle, Last) Dock Woodard				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lela ?			
19a. INFORMANT'S NAME (Type/Print) Bobbie Wright				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Wabash Avenue, Baltimore, MD 21215			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) Metro Crematory		DATE 6/24	20c. LOCATION — City or Town, State Catonsville, MD		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Sylvia Adams		22. NAME AND ADDRESS OF FACILITY Marshall W. Jones, Jr. Funeral HM PA 4101 Edmondson Ave. Balto. MD 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Congestive Heart Failure DUE TO (OR AS A CONSEQUENCE OF): Atherosclerotic Heart Disease							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. -Pneumonia -Renal Insufficiency						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED 		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 02332					
29b. SIGNATURE AND TITLE OF CERTIFIER Sylvia S. Schaefer		29d. DATE SIGNED (Month, Day, Year) ► 6/21/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Shaeffer S. Schaefer Union Hospital, Elkton, Md. 21921							
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Juli Schaefer Roselli					



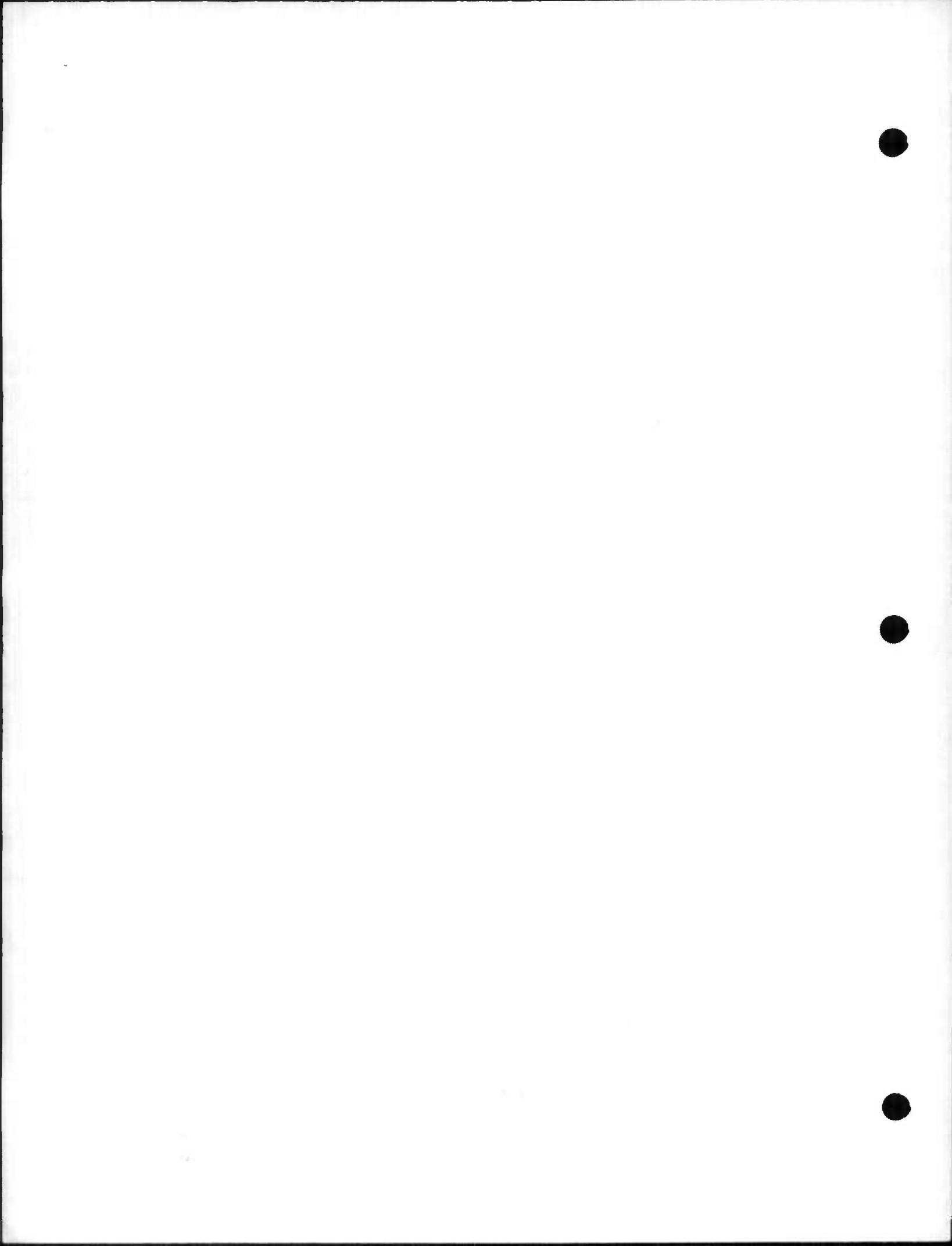
95 19416

FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

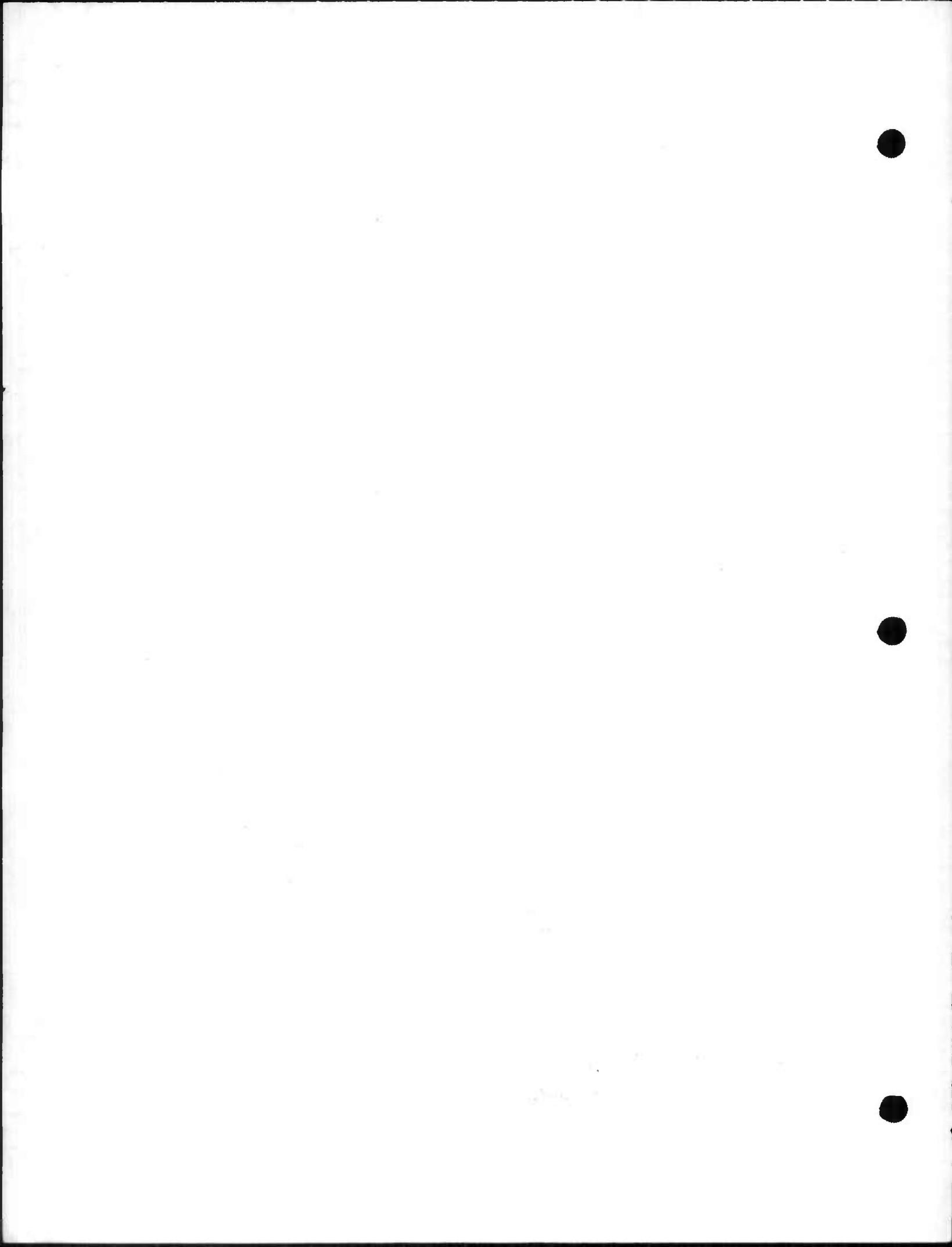
1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH 11:15p M		
<i>Alene Elizabeth Weaver</i>		JUNE 23, 1995						
4. SOCIAL SECURITY NUMBER 218-52-7780		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs, last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 1, 1898		8. BIRTHPLACE (State or Foreign Country) North Carolina
8a. FACILITY NAME (If not institution, give street and number) Pleasant Living Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Edgewater				9c. COUNTY OF DEATH Anne Arundel		
RESIDENCE OF DECEASED		10c. CITY, TOWN OR LOCATION Edgewater				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10a. STATE MD	10b. COUNTY Anne Arundel	10e. STREET AND NUMBER Washington Street				10f. ZIP CODE 21037	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEASED OF NISPCAN ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Fiscal Analyst				16b. KIND OF BUSINESS/INDUSTRY Dept. of Justice		
17. FATHER'S NAME (First, Middle, Last) John W. Goodwin		18. MOTHER'S NAME (First, Middle, Maiden Surname) Addie M. Crabtree						
19a. INFORMANT'S NAME (Type/Print) Charlotte Koontz		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 449 Deer Path, Calabash, NC 28467						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery				DATE 6/27	20c. LOCATION — City or Town, State Brentwood, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas J Hardesty</i>		22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Ave. Annapolis, MD 21401						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. <u>Natural causes</u> DUE TO (OR AS A CONSEQUENCE OF):								
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST Advanced Dementia DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>ADVANCED DEMENTIA</u>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D 41698		29d. DATE SIGNED (Month, Day, Year) ► 6-26-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Hamilton, 205 Ridgely Ave. Annapolis, MD 21401								
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Jahn Shuler Randall</i>						



FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		KEVIN Goodwin WILGIS				2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 06:16 A.M.	
4. SOCIAL SECURITY NUMBER 615-84-6943		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 31 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) June 27, 1963		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 2700 SISSON ST.		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH Baltimore City			
RESIDENCE OF DECEASED									
10a. STATE Maryland	10b. COUNTY Balto. City	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 2633 Hampden Avenue		10f. ZIP CODE 21211				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Unknown		16b. KIND OF BUSINESS/INDUSTRY Unknown					
17. FATHER'S NAME (First, Middle, Last) Francis Talbott Wilgis, Sr.					18. MOTHER'S NAME (First, Middle, Maiden Surname) Marjorie Lee Harris				
19a. INFORMANT'S NAME (Type/Print) Francis T. Wilgis, Sr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2633 Hampden Avenue Baltimore, Maryland 21211							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metro Crematory		DATE 6/24		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Terry Hens Carpenter</i>		22. NAME AND ADDRESS OF FACILITY Burgee-Henss Funeral Home 3631 Falls Road Baltimore, MD 21211							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. NARCOTIC AND ALCOHOL INTOXICATION DUE TO (OR AS A CONSEQUENCE OF):									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) VACANT WAREHOUSE							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input checked="" type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) FOUND 6-23-95		28b. TIME OF INJURY UNKNOWN	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) BUILDING		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 2700 SISSON ST., BALTIMORE, MD.							
29a. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Lohman, MD</i>		29c. LICENSE NUMBER OCME				29d. DATE SIGNED (Month, Day, Year) ► JUNE 23, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>John Lohman, MD</i>		111 Penn Street, Baltimore, Maryland 21201							
31. DATE FILMED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Jahnne Shuster-Randall</i>							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

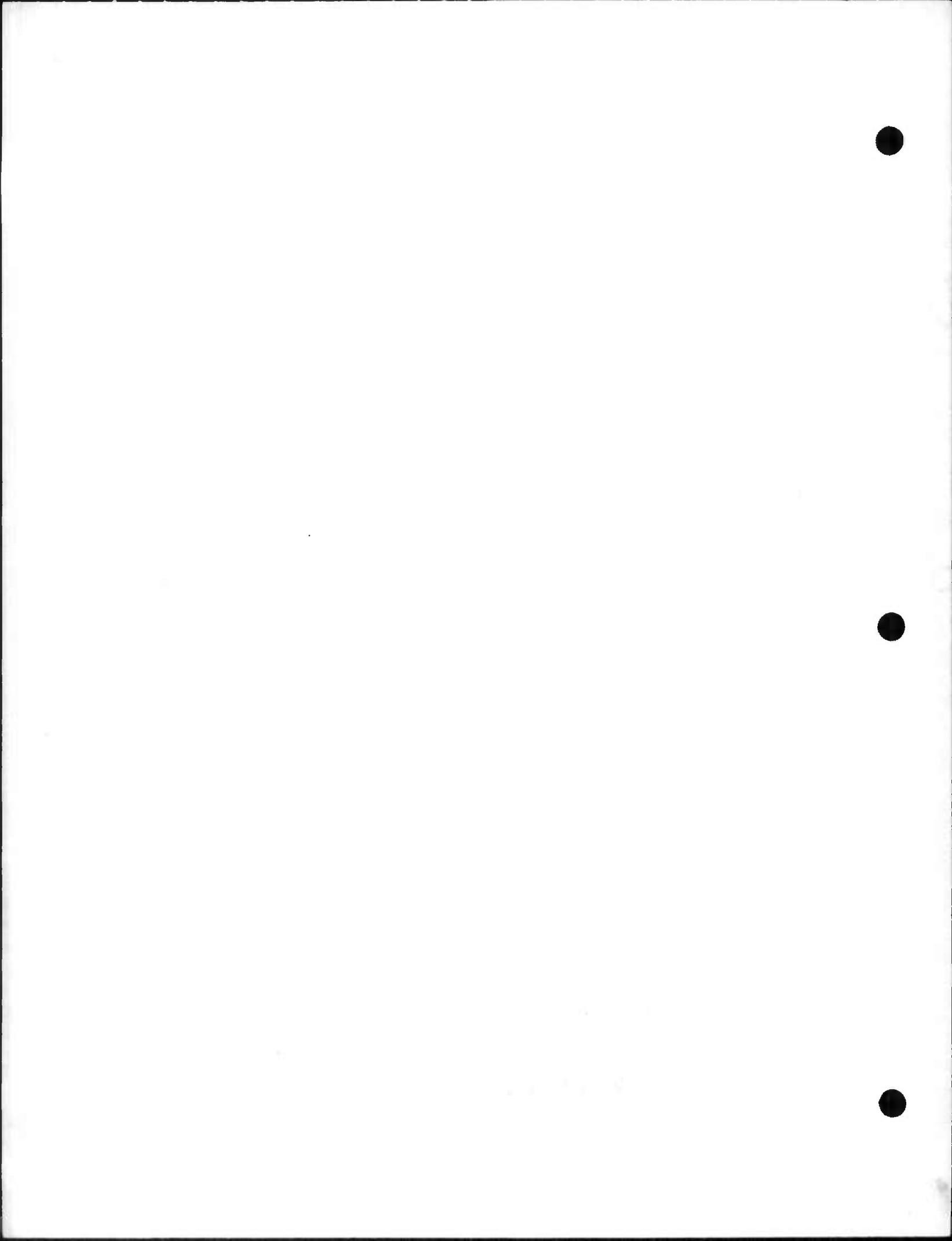
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR		MAMIE RUTH WILLIAMS								2. DATE OF DEATH MONTH DAY YEAR JUNE 24 1995		3. TIME OF DEATH 7:40 P.M.	
4. SOCIAL SECURITY NUMBER 214-26-5224		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) JUN. 17, 1928		8. BIRTHPLACE (State or Foreign Country) N. CAROLINA	
9a. FACILITY NAME (If not institution, give street and number) THE UNION MEMORIAL HOSP.		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY								9c. COUNTY OF DEATH n/a			
10a. STATE MARYLAND		10b. COUNTY n/a		10c. CITY, TOWN OR LOCATION BALTIMORE CITY								10d. INSIDE CITY <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 3120 HARFORD ROAD		10f. ZIP CODE 21218								10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 TH		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) — SEAMSTRESS								16b. KIND OF BUSINESS/INDUSTRY own Home			
17. FATHER'S NAME (First, Middle, Last) HENRY BATTLE		18. MOTHER'S NAME (First, Middle, Maiden Surname) LULA EBRON											
19a. INFORMANT'S NAME (Type/Print) DELORES DENNIS REDD		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 609 E. 36 TH, BALTIMORE, MARYLAND 223 # 18											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION /Name of cemetery, crematory or other place/ BALTIMORE CEMETERY								DATE 6-29	20c. LOCATION — City or Town, State BALTIMORE, MARYLAND		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bernard D Johnson</i>		22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FH.-1101 E. NORTH AVENUE											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. BRADY CARDIA DUE TO (OR AS A CONSEQUENCE OF):													
b. HYPOTENSION DUE TO (OR AS A CONSEQUENCE OF):													
c. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF):													
d. METABOLIC ACIDOSIS DUE TO (OR AS A CONSEQUENCE OF):													
Approximate Interval Between Onset and Death 30' 4h 2 weeks 8h													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)										28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Paul W. Rassam</i>		29c. LICENSE NUMBER AT243 8946		29d. DATE SIGNED (Month, Day, Year) ► JUNE 24, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAUL RASSAM. 3223 SAINT PAUL STREET - BALTIMORE, MD 21218													
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE <i>Jean Shuler Herrell</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

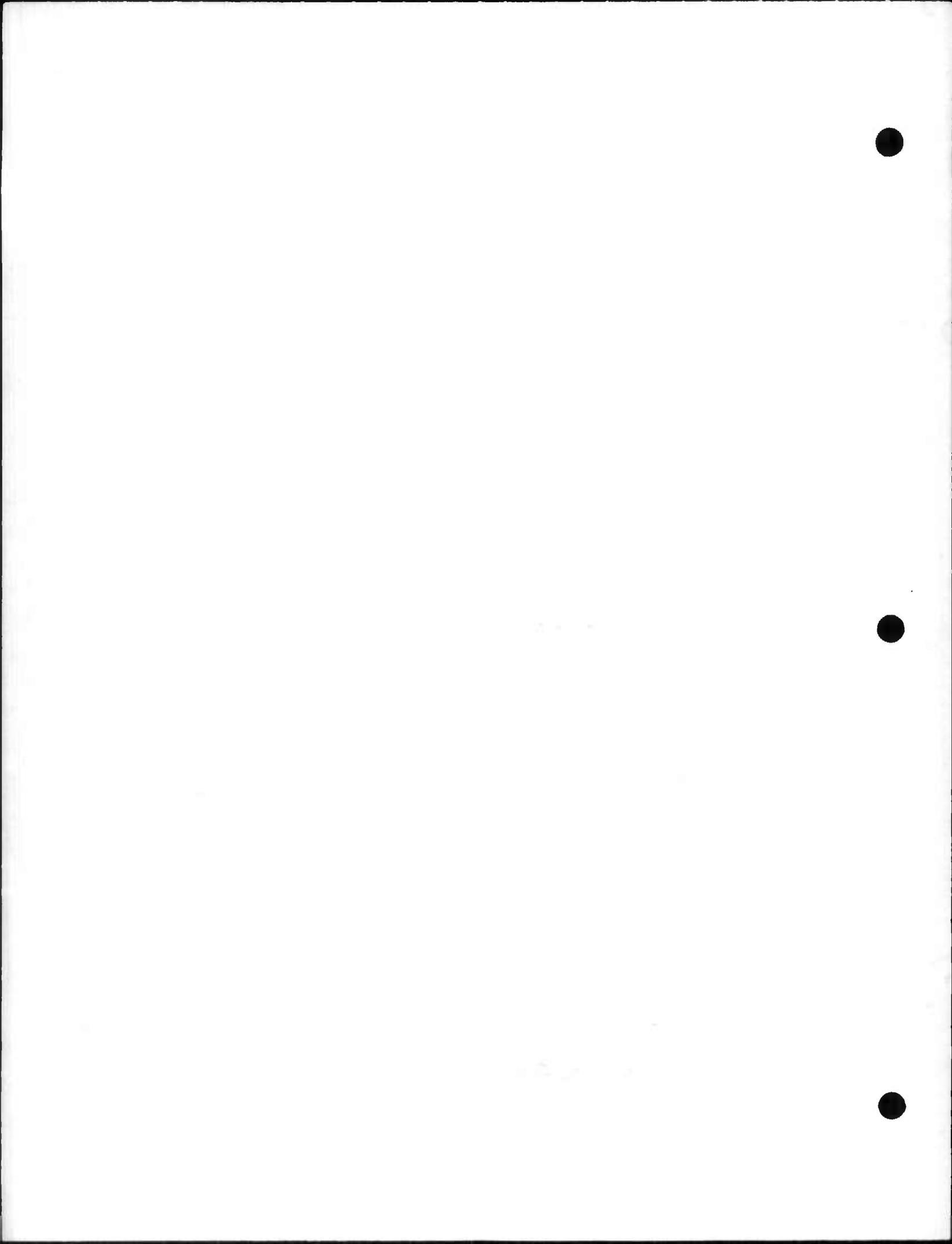
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19419

1. DECEDENT'S NAME (First, Middle, Last) FRANCES ELIZABETH WELLS						2. DATE OF DEATH MONTH DAY YEAR JUNE 24 1995	3. TIME OF DEATH HOUR MINUTE 2:30 PM		
4. SOCIAL SECURITY NUMBER 214 24 0508			5. SEX M	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7. DATE OF BIRTH (Month, Day, Year) 11-10-26	8. BIRTHPLACE (State or Foreign Country) Md	
9a. FACILITY NAME (If not institution, give street and number) Stella Maris Hospice			9b. CITY, TOWN OR LOCATION OF DEATH N. A.				9c. COUNTY OF DEATH Baltimore		
RESIDENCE OF DECEDENT									
10a. STATE Md	10b. COUNTY N. A.	10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
10e. STREET AND NUMBER 2119 Southern Ave				10f. ZIP CODE 21214			10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY Home			
17. FATHER'S NAME (First, Middle, Last) N. A.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Costley					
19a. INFORMANT'S NAME (Type/Print) Mitchell Wells				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2119 SOUTHERN AVE BALTO. MD 21214					
20a. METHOD OF DISPOSITION Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <input type="checkbox"/>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PLEASANT Rest Cem			DATE 6/27	20c. LOCATION — City or Town, State Baltimore County, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph B. Locke Jr.				22. NAME AND ADDRESS OF FACILITY Locke Funeral Home 1304 N Central St					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → COLON CANCER									Approximate Interval Between Onset and Death 7 yrs.
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <p style="text-align: center;">{</p> <p>b. DUE TO (OR AS A CONSEQUENCE OF): _____</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF): _____</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF): _____</p>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. BREAST MASS							24a. WAS AN AUTOPSY PERFORMED? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) HOSPICE					
27. MANNER OF DEATH Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined <input type="checkbox"/>				28a. DATE OF INJURY (Month, Day, Year) M 1 1995	28b. TIME OF INJURY 1:00 PM	28c. INJURY AT WORK? NO <input type="checkbox"/> YES <input checked="" type="checkbox"/>	28d. DESCRIBE HOW INJURY OCCURRED		
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Kendall Faulkner				29c. LICENSE NUMBER D 25643			29d. DATE SIGNED (Month, Day, Year) 6/26/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. KENDALL FAULKNER 2300 DULANEY VALLEY ROAD TOWSON, MD 21204									
31. DATE FILED WITH DEPT. OF HEALTH AND MENTAL HYGIENE JUN 27 1995 John [Signature]									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. <i>95 19420</i>				
1. DECEDENT'S NAME (First, Middle, Last) Martha Yevzeoff							2. DATE OF DEATH MONTH June DAY 20 YEAR 1995		3. TIME OF DEATH 19 12 P M				
4. SOCIAL SECURITY NUMBER 218-66-1506		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>		7. DATE OF BIRTH Month Day Year APRIL 20, 1916		8. BIRTHPLACE (State or Foreign) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) SINAI HOSPITAL							9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH N/A				
10a. STATE MARYLAND		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION BALTIMORE					10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER 7121 PARK HEIGHTS AVE, APT. 202							10f. ZIP CODE 21215		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify			14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) HOUSEWIFE			16b. KIND OF BUSINESS/INDUSTRY OWN HOME								
17. FATHER'S NAME (First, Middle, Last) MYER LEVY							18. MOTHER'S NAME (First, Middle, Maiden Surname) TEMA KRIEGER						
19a. INFORMANT'S NAME (Type/Print) MRS. BARBARA ZERIVITZ							19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 AUTUMN WIND COURT REISTERSTOWN, MD 21136						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BETH TETLOH			DATE 6-22-1995		20c. LOCATION — City or Town, State BALTIMORE, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Judie L. Sullivan</i>							22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN ROAD BALTIMORE, MD 21215						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Intracerebral hemorrhage <small>DUE TO (OR AS A CONSEQUENCE OF):</small> b. c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
Approximate Interval Between Onset and Death 17 hours													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Smith Medical Resident</i>		29c. LICENSE NUMBER A52402321589812		29d. DATE SIGNED (Month, Day, Year)		<i>JUNE 20, 1995</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Sam Sevitz		31. DATE FILED (Month, Day, Year) JUN 2 1995 <i>John J. Smith</i>											
		32. REGISTRATION SIGNATURE											

1000

DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

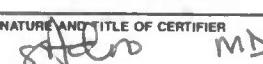
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

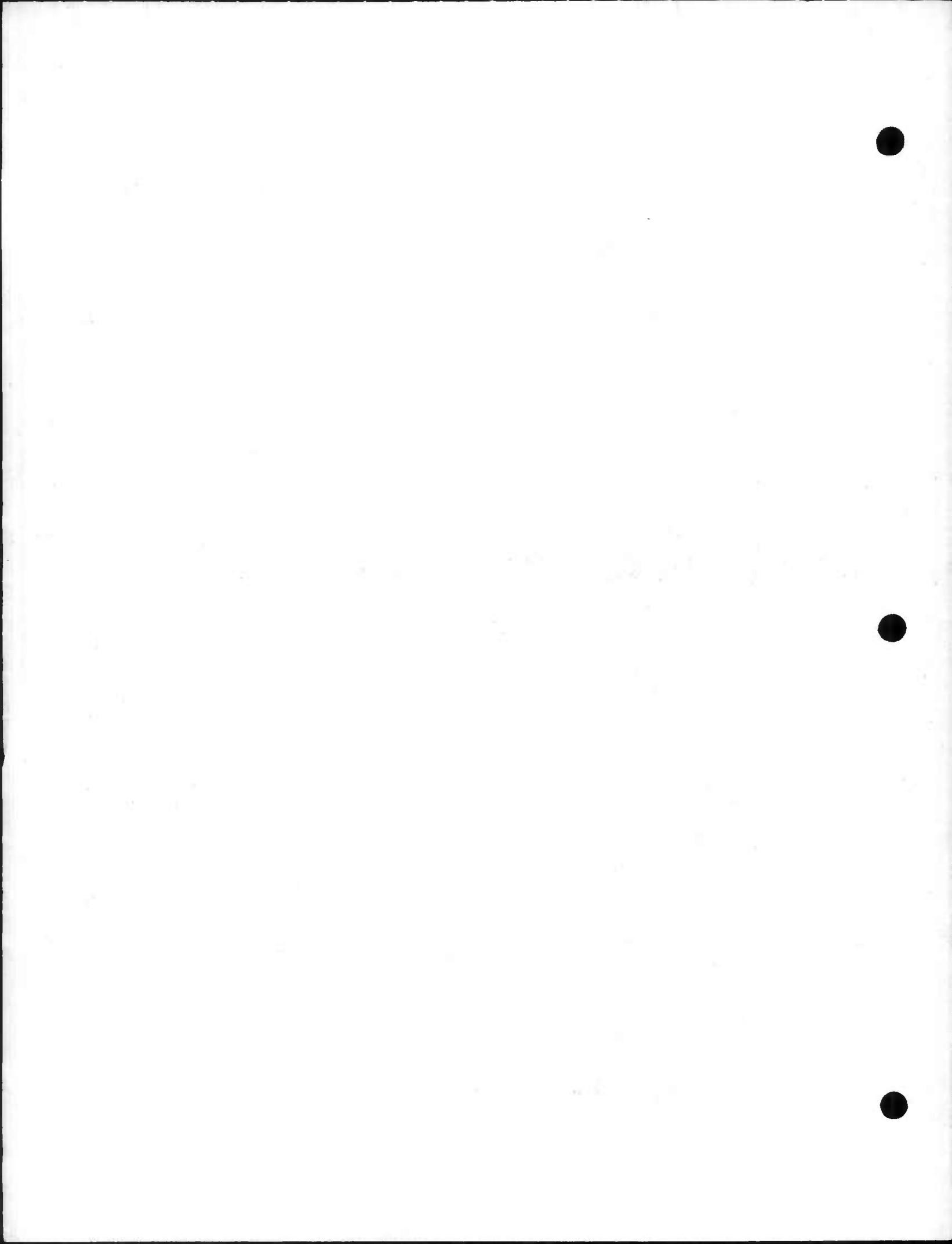
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1 - FOR STATE REGISTRAR		Alvin Frederick Zick								2. DATE OF DEATH MONTH 06 DAY 25 YEAR 1995		3. TIME OF DEATH 10:45 P.M.			
1. DECEDENT'S NAME (First, Middle, Last)		4. SOCIAL SECURITY NUMBER 219-18-1847		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 5, 1924		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) St. Agnes 900 Caton Avenue		21229 Baltimore								9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH N/A			
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Arbutus								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 5215 Larlin Road		10f. ZIP CODE 21227								10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:								14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Inspector		16b. KIND OF BUSINESS/INDUSTRY Automobile											
17. FATHER'S NAME (First, Middle, Last) Frederick G. Zick		18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Huether													
19a. INFORMANT'S NAME (Type/Print) Mary Zick		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5215 Larlin Road Arbutus, Maryland 21227													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) Crestlawn Memorial		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE 6/29								20c. LOCATION — City or Town, State Marriotsville, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Ambrose Funeral Home 1328 Sulphur Spring Road								Arbutus 21227					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CONGESTIVE HEART FAILURE												3 years.			
b. CORONARY ARTERY DISEASE												4 years.			
c. (Underline)												(Underline)			
d. (Underline)												(Underline)			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. DIABETES COLON CANCER												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER D 46893								29d. DATE SIGNED (Month, Day, Year) ► 06 25 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Clarence Sarkodee - Adeo.															
31. DATE FILED (Month, Day, Year) JUN 27 1995		32. REGISTRAR'S SIGNATURE Julia Shandor Randall													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

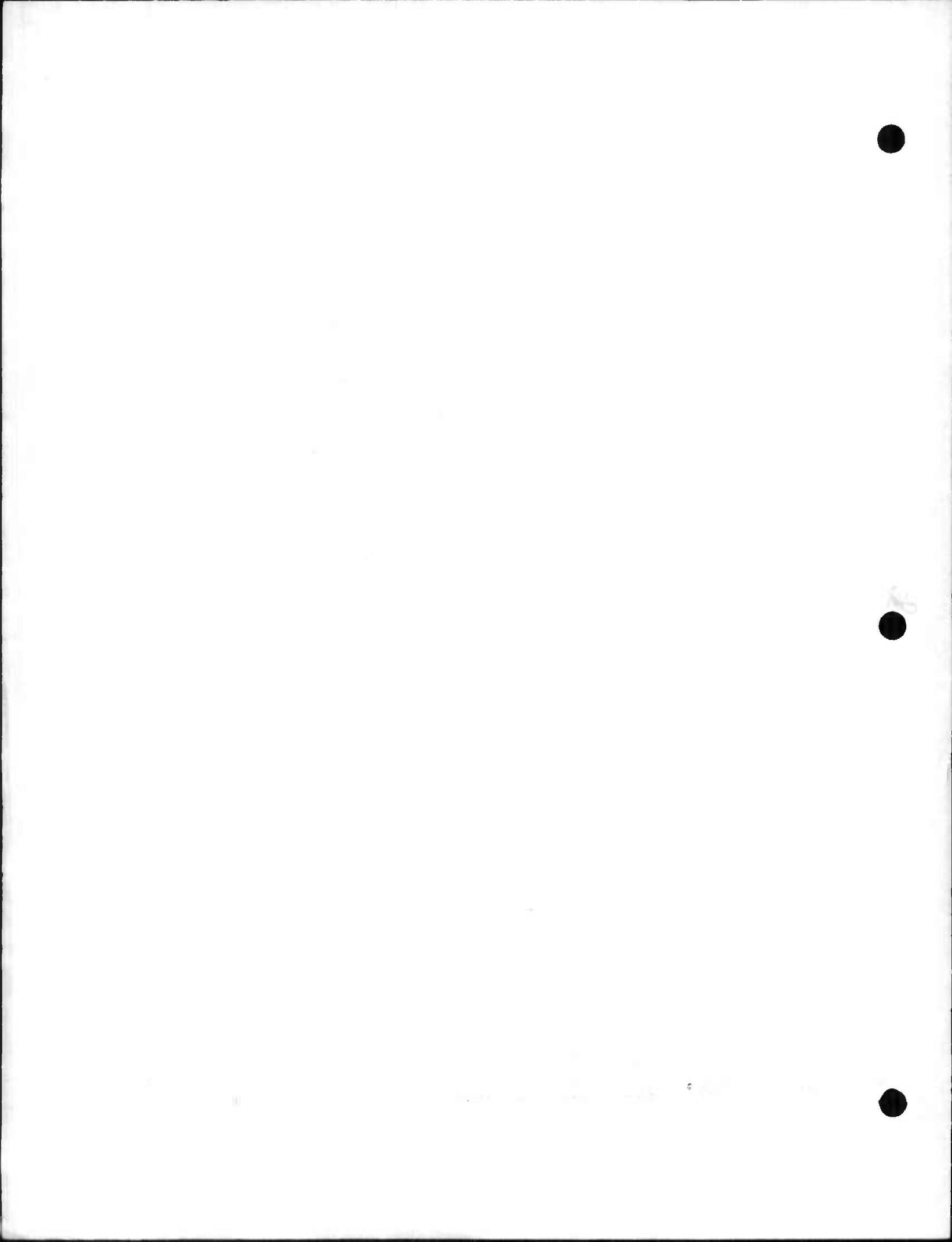
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1 - FOR STATE REGISTRAR												
1. DECEDENT'S NAME (First, Middle, Last)										2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
BARBARA E. ADDISON										JUNE 12 1995	11:30 a.m.	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.					7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)	
577-56-8537		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	55 YRS.	MONTHS	DAYS	HOURS	MIN.	Mar. 6, 1940				Pennsylvania
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH	
Washington Adventist Hospital										Takoma Park	Montgomery	
RESIDENCE OF DECEDENT												
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
Md.	Prince Georges	Olney										
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?	
3708 Briars Road										20832	United States	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced												
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)								16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12)		Clerical								Private Industry		
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)		
Ludlow Thornton										Clarice Wallace		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Valencia Griesby		5909 Fisher Road, Temple Hills, Md. 20748										
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)								DATE	20c. LOCATION — City or Town, State	
		Harmony Memorial Park								6/16/95	Landover, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE										22. NAME AND ADDRESS OF FACILITY		
										R. N. Horton Co. Morticians, Inc. 600 Kennedy Street, N. W., Wash., DC		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												
a. bleeding / Hypothermia												
b. Liver Failure, Sepsis, renal Failure												
c. Hepatitis B infection												
d. Dialysis (Chronic)												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Diabetes mellitus peripheral vascular Disease												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)										
		HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
1 <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one)		CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER								29d. DATE SIGNED (Month, Day, Year)		
Rashid Bhai Naini		D 39372								► 6/12/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
RASHID BAGHOLI-NAINI (WAH)												
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE										
JUN 29 1995												

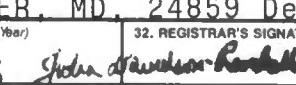


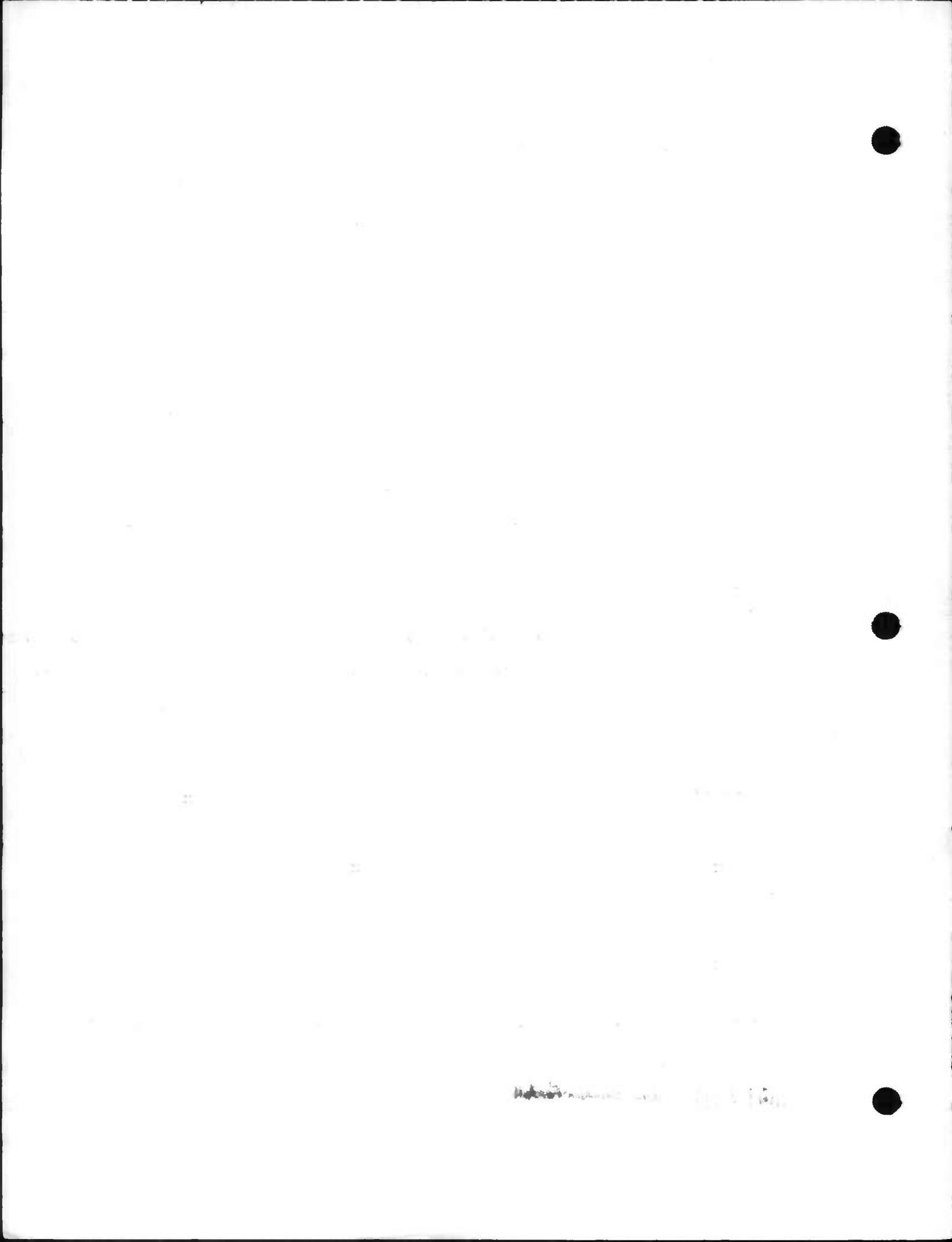
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) JOHN THOMAS ABBOTT										2. DATE OF DEATH MONTH DAY YEAR June 8, 1995	3. TIME OF DEATH 2200 PM M
4. SOCIAL SECURITY NUMBER 218-16-5545		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 14, 1922		8. BIRTH PLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (if not institution, give street and number) 23355 Osborne Webster Road										9b. CITY, TOWN OR LOCATION OF DEATH Deal Island	9c. COUNTY OF DEATH Somerset
10a. STATE Maryland		10b. COUNTY Somerset		10c. CITY, TOWN OR LOCATION Deal Island				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 23355 Osborne Webster Road						10f. ZIP CODE 21821		10g. CITIZEN OF WHAT COUNTRY? U.S.			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) U.S. Army Retired		16b. KIND OF BUSINESS/INDUSTRY Armed Forces							
17. FATHER'S NAME (First, Middle, Last) Henry Abbott		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Abbott									
19a. INFORMANT'S NAME (Type/Print) Mr. Chris Pittas		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO Box 874/3616 Stockyard Rd., Fruitland, Md.				20c. LOCATION — City or Town, State Deal Island, Md.					
20e. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. Johns Cemetery		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. Johns Cemetery		DATE 6/12		20c. LOCATION — City or Town, State Deal Island, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. Congestive Heart failure DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Onset and Death 6 months			
b. Hypertension heart disease DUE TO (OR AS A CONSEQUENCE OF):								10 yrs			
c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. diabetes								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29g. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D10818				29d. DATE SIGNED (Month, Day, Year) 6-12-95					
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE 						DHMH-16 Rev 1/89			
F.C. SUTTER, MD, 24859 Deal Island Rd., Dames Quarter, Md. 21821											



TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

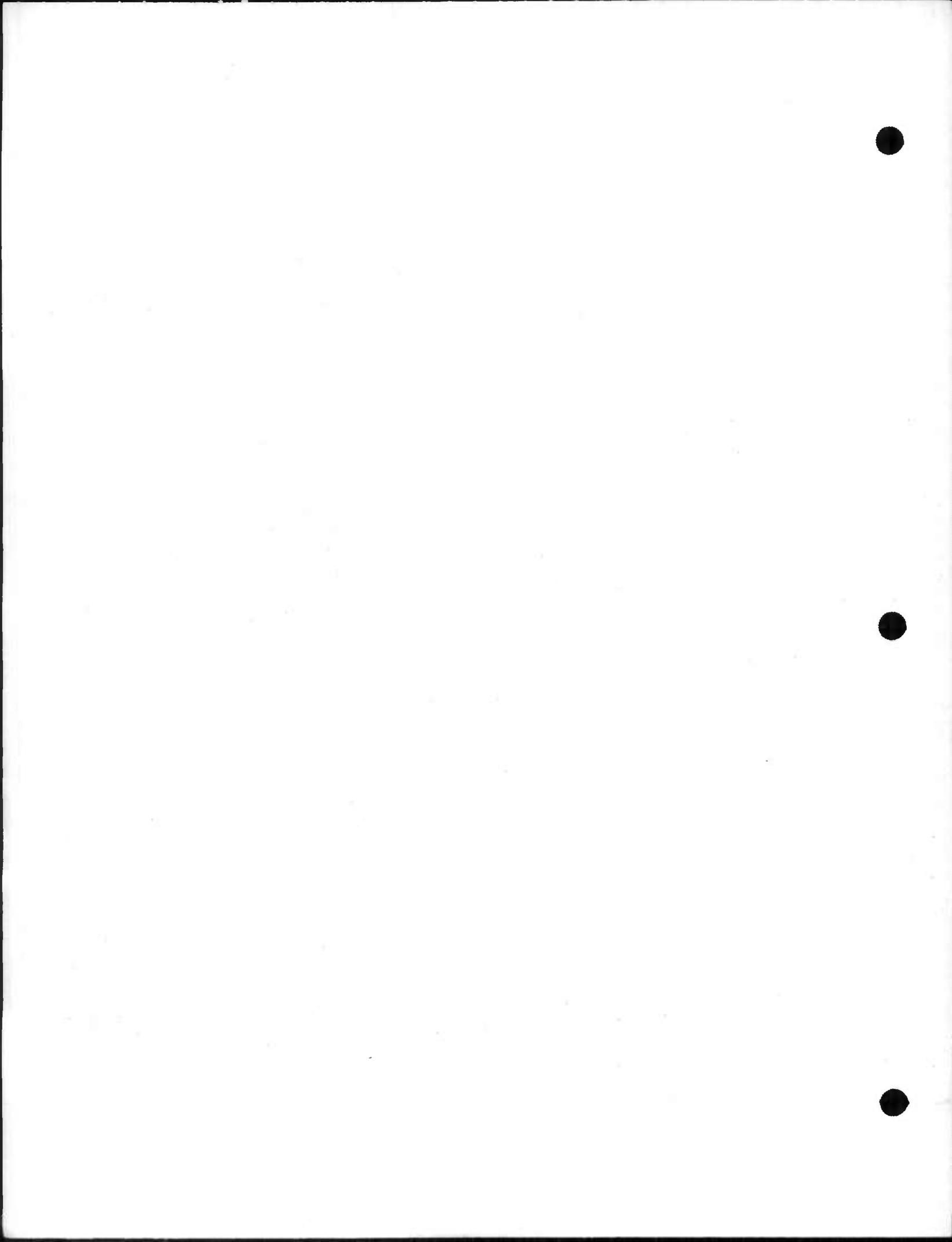
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FINANCIAL DIRECTOR

Amended #206 6/12/95 MRT Montgomery 95 County
FOR STATE REGISTRAR
1 - STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH REC. NO.

CERTIFICATE OF DEATH							REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)							2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 1:10 P M
Horton S. Allen		S. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Oct. 29, 1911	8. BIRTHPLACE (State or Foreign Country) Massachusetts		
9a. FACILITY NAME (If not institution, give street and number) 230 Great Falls Road				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT		10e. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Rockville		
10e. STREET AND NUMBER 230 Great Falls Road				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2		16b. KIND OF BUSINESS/INDUSTRY Office Manager		16d. KIND OF BUSINESS/INDUSTRY Chemical Company		
17. FATHER'S NAME (First, Middle, Last) Horton S. Allen				16. MOTHER'S NAME (First, Middle, Maiden Surname) not available				
19e. INFORMANT'S NAME (Type/Print) Mildred Ward Allen				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 230 Great Falls Road, Rockville, Maryland 20850				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. LOCATION — City or Town, State Bethesda, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barbara J. McMullen Lawrence</i>				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc., 300 West Montgomery Avenue, Rockville, Maryland 20850-2805				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Carcinoma head of the pancreas DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____								
Approximate Interval Between Onset and Death								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____								
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		26d. DESCRIBE HOW INJURY OCCURRED 26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald L. Bucy MD.</i>				29c. LICENSE NUMBER D00957		29d. DATE SIGNED (Month, Day, Year) ► June 7, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald L. Bucy, M.D. 809 Veirs Mill Road, Rockville, MD 20851								
31. DATE FILED (Month, Day, Year) JUN 08 1995				32. REGISTRAR'S SIGNATURE <i>Susan Anderson</i>				



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

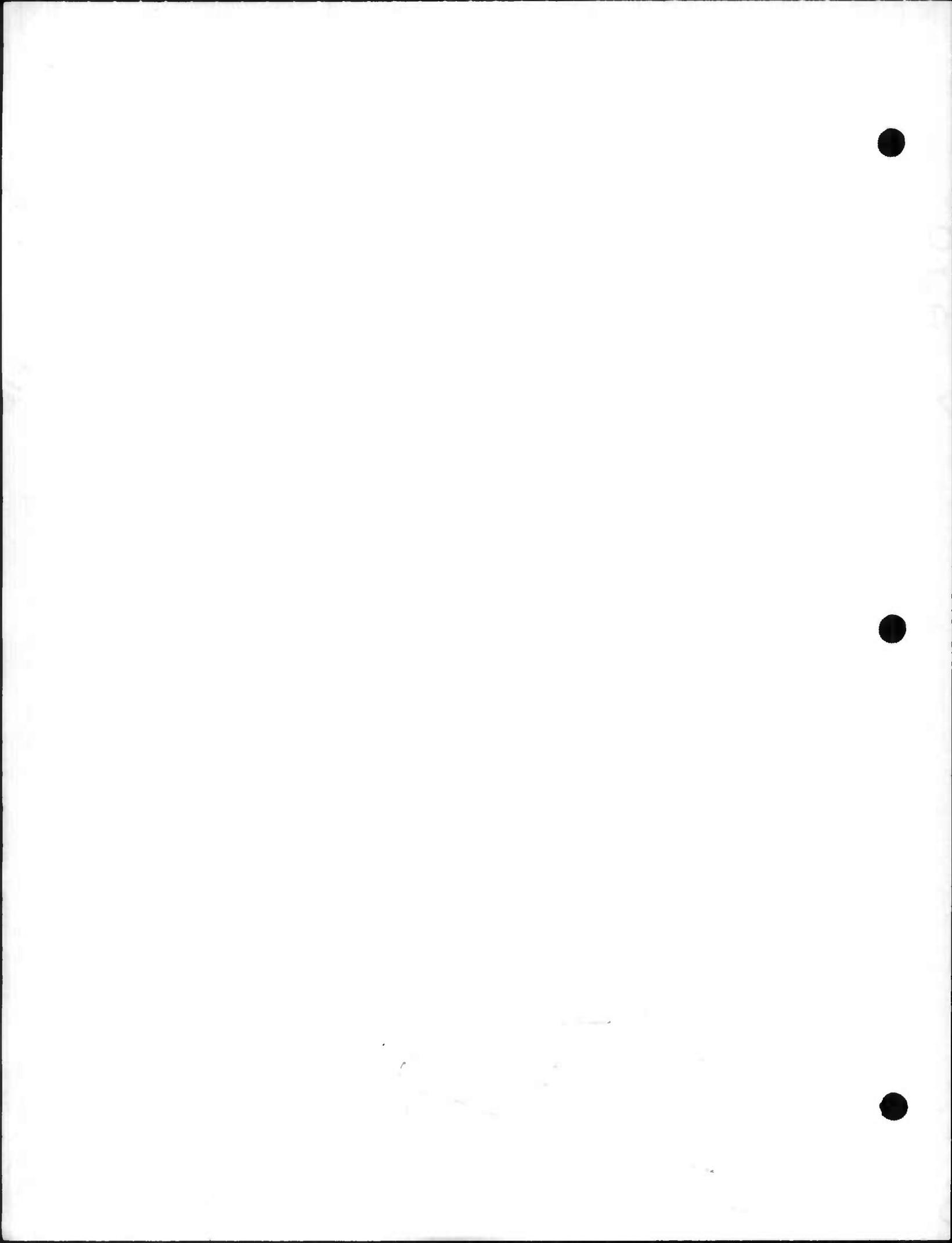
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR													
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH P.M.	
CONSUELO ARGUETA AGUILAR											JUNE 7, 1995	9:45 P.M.	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 38 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 9, 1957		8. BIRTHPLACE (State or Foreign Country) El Salvador			
9a. FACILITY NAME (If not institution, give street and number) 10320 Inwood Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring											
RESIDENCE OF DECEDENT											9c. COUNTY OF DEATH Montgomery		
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring						10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 10320 Inwood Avenue		10f. ZIP CODE 20902						10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify: El Salvadorian			14. RACE — American Indian, Black, White, etc. Specify: Hispanic					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Housekeeper			16b. KIND OF BUSINESS/INDUSTRY Cleaning Industry								
17. FATHER'S NAME (First, Middle, Last) Manuel Argueta		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lidia Unobtainable											
19a. INFORMANT'S NAME (Type/Print) Abel Aguilar		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10320 Inwood Avenue, Silver Spring, Maryland 20902											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			DATE 6/9		20c. LOCATION — City or Town, State Silver Spring, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen J. Stahl</i>		22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>GASTRIC CARCINOMA</i>													
Approximate Interval Between Onset and Death 6 mos													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
<p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen Stahl MD</i>		29c. LICENSE NUMBER D18219		29d. DATE SIGNED (Month, Day, Year) ► 6-9-95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEPHEN STAHL MD 8300 CORPORATE DR, LANCOVER MD 20785													
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>Julie Shuster-Pattell</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

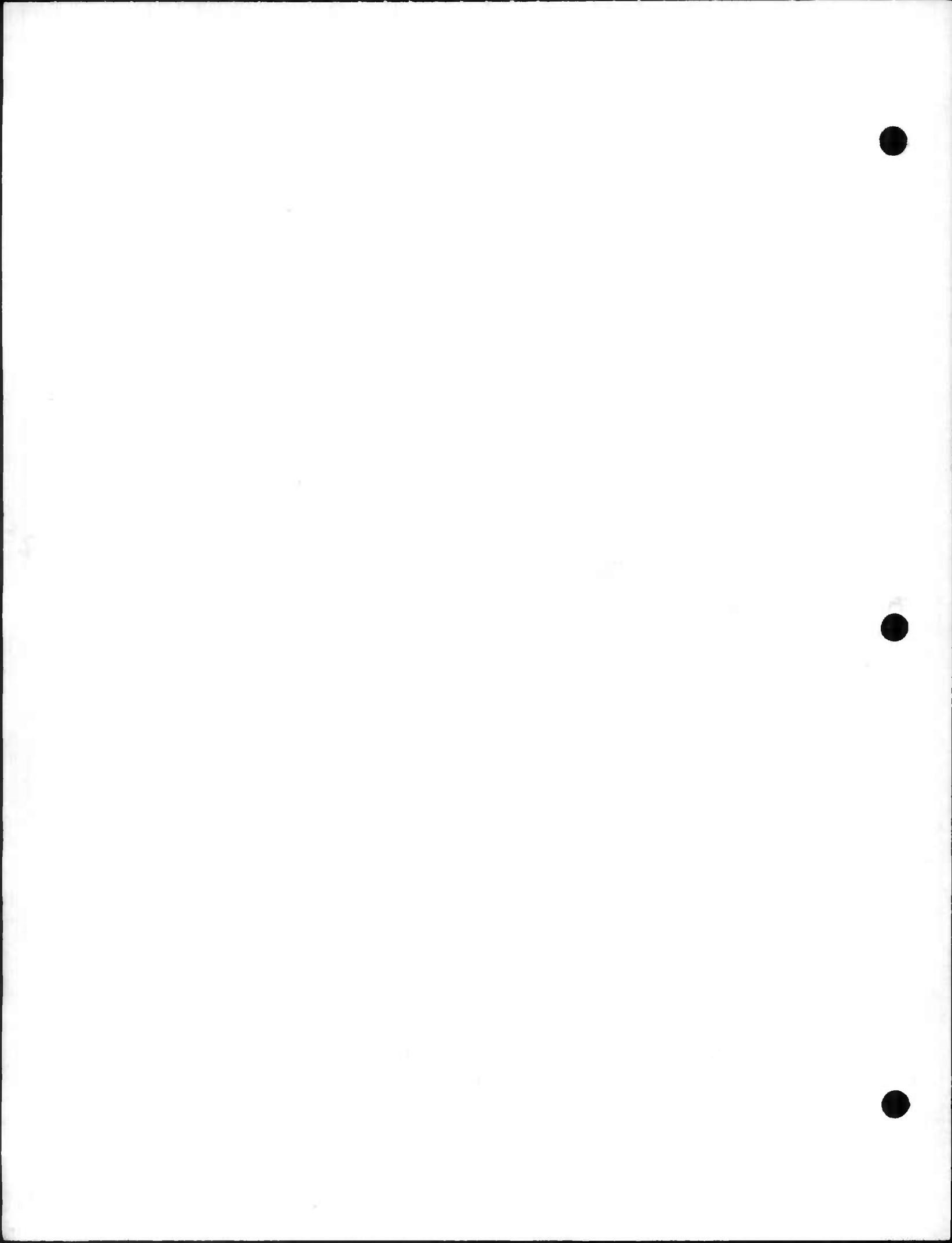
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 8, 1995										3. TIME OF DEATH 4: 20 P M	
1. DECEDENT'S NAME (First, Middle, Last) Albert Roland Allison												7. DATE OF BIRTH (Month, Day, Year) Feb. 23, 1912	
4. SOCIAL SECURITY NUMBER 083-36-1555		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Pennsylvania					
9a. FACILITY NAME (If not institution, give street and number) Montgomery General Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Olney	
9c. COUNTY OF DEATH Montgomery												10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10b. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Olney		10f. ZIP CODE 20832-2105		10g. CITIZEN OF WHAT COUNTRY? United States					
10e. STREET AND NUMBER 3905 Queen Mary Drive													
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 5+		13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) —		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Engineer		16b. KIND OF BUSINESS/INDUSTRY Chemical Engineering									
17. FATHER'S NAME (First, Middle, Last) Vincent Ankadavitch		18. MOTHER'S NAME (First, Middle, Maiden Surname) Petronella Kurtinaitis											
19e. INFORMANT'S NAME (Type/Print) Gregg Allison		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3905 Queen Mary Drive, Olney, MD 20832-2105											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.		20c. DATE June 13, 1995		20c. LOCATION — City or Town, State Bethesda, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death HOURS					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. MULTIPLE ORGAN FAILURE DUE TO (OR AS A CONSEQUENCE OF):		b. STAPHYLOCOCCUS AUREUS Pneumonia DUE TO (OR AS A CONSEQUENCE OF):		c. _____ DUE TO (OR AS A CONSEQUENCE OF):		d. _____ DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death DAYS					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURED	
				26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29g. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER DSB457		29d. DATE SIGNED (Month, Day, Year) ► 6-9-95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) N. GOYAL, MS 1811 PRINCE PHILIP DR OLNEY MD													
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE Julia Shuler Marshall											



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

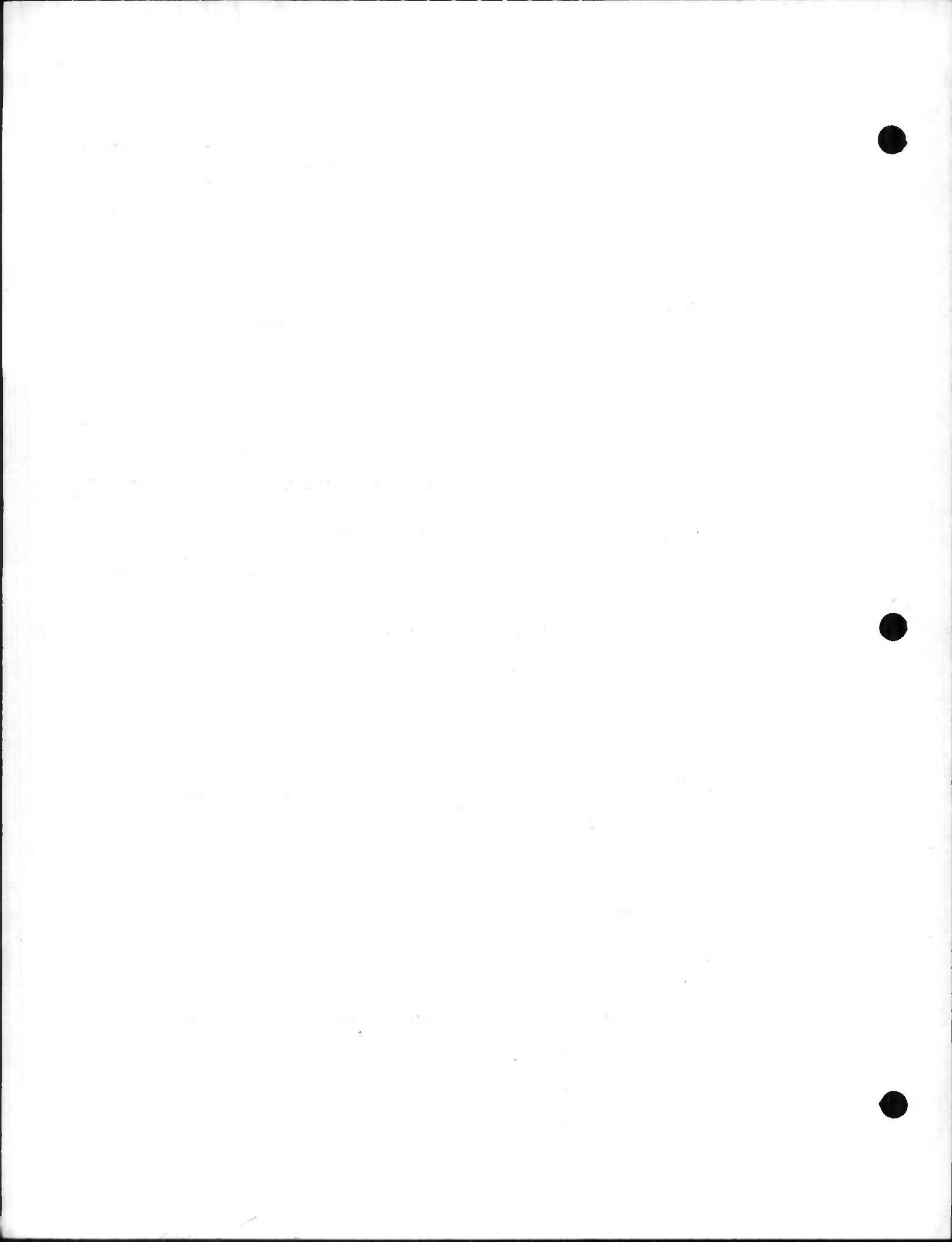
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		ARRILL								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
DANIEL										JUNE 08 1995	0500 AM
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Oct 18 1921		8. BIRTHPLACE (State or Foreign Country) New York	
261-48-1031											
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH Rockville								9c. COUNTY OF DEATH Montgomery	
Shady Grove Hospital											
RESIDENCE OF DECEDENT											
10a. STATE MD	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Gaithersburg								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 411 Christopher Avenue		10f. ZIP CODE 20879								10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW2				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4+				16b. KIND OF BUSINESS/INDUSTRY Economist				Government	
17. FATHER'S NAME (First, Middle, Last) Abraham Arrill		18. MOTHER'S NAME (First, Middle, Maiden Surname) Beckie (Unknown)									
19a. INFORMANT'S NAME (Type/Print) Ruth Arrill		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State) 411 Christopher Avenue Gaithersburg MD 20879									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Judean Memorial Gardens				DATE		20c. LOCATION — City or Town, State 6-13 Olney MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Edw		22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. <i>Probable Basilar Artery Occlusion</i> DUE TO (OR AS A CONSEQUENCE OF): days											
c. DUE TO (OR AS A CONSEQUENCE OF): days											
d.											
Approximate Interval Between Onset and Death											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST {											
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus</i> <i>Coronary Artery Disease</i>											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Nomicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one)		1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Stephen Newman		29c. LICENSE NUMBER D15046		29d. DATE SIGNED (Month, Day, Year) ► 6/8/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen Newman 11500 Old Georgetown Rd Rockville MD 20852											
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE John Dawson Randsell									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 6 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

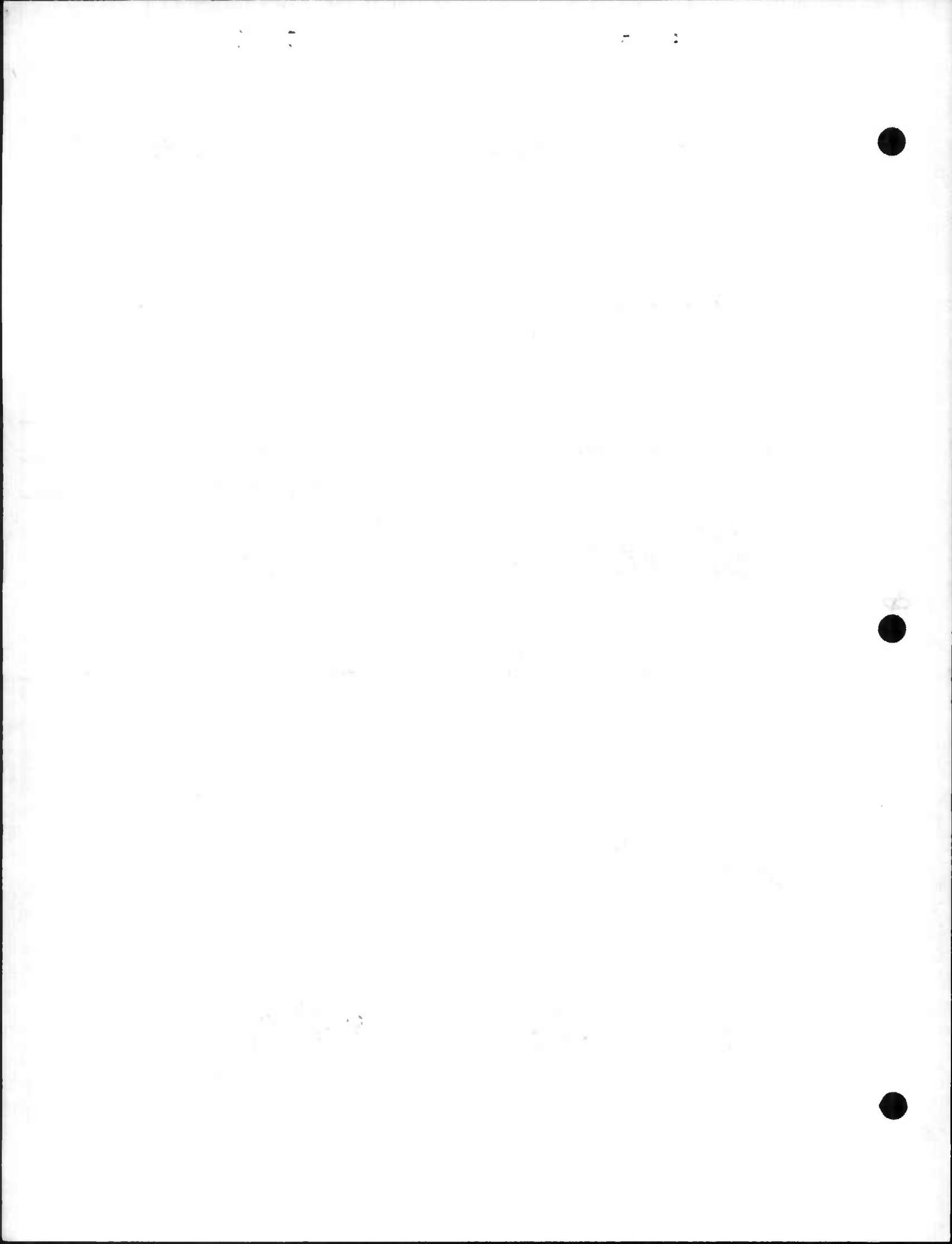
WILLIAM GALE BENNETT, JR.

95 19428

1 - STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>William Bennett</i>						2. DATE OF DEATH MONTH 6 DAY 12 YEAR 95	3. TIME OF DEATH 5A			
4. SOCIAL SECURITY NUMBER 219-88-5739		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 17 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) AUG. 19, 1977	8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) UNIVERSITY OF MARYLAND HOSPITAL			9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE			9c. COUNTY OF DEATH BALTIMORE CITY				
RESIDENCE OF DECEASED										
10a. STATE MARYLAND	10b. COUNTY DORCHESTER	10c. CITY, TOWN OR LOCATION EAST NEW MARKET				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 5647 SPRINGDALE ROAD			10f. ZIP CODE 21631			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: WHITE					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) STUDENT			16b. KIND OF BUSINESS/INDUSTRY -					
17. FATHER'S NAME (First, Middle, Last) WILLIAM G. BENNETT, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNA L. APPLE						
19a. INFORMANT'S NAME (Type/Print) ANNA L. WINGATE			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5647 SPRINGDALE ROAD, EAST NEW MARKET MD 21631							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EAST NEW MARKET CEMETERY			DATE 6/15	20c. LOCATION — City or Town, State EAST NEW MARKET, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard Beller</i>			22. NAME AND ADDRESS OF FACILITY ZELLER FUNERAL HOME, 106 MAIN STREET, P. O. BOX 207, EAST NEW MARKET, MD 21631							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiorespiratory Failure</i>										
a. DUE TO (OR AS A CONSEQUENCE OF): <i>Pulmonary Edema</i>										
b. DUE TO (OR AS A CONSEQUENCE OF): <i>Rhabdomyosarcoma</i>								<i>3 days</i>		
c. DUE TO (OR AS A CONSEQUENCE OF):								<i>6 mo.</i>		
d.										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH Natural 5 <input type="checkbox"/> Pending Investigation Accident 6 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jal Rite</i>		29c. LICENSE NUMBER P06803			29d. DATE SIGNED (Month, Day, Year) ► 6-12-95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Rubenstein 22 So. Green St., Univ. of Maryland, Balt., MD										
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE <i>Jahn Shulman-Randall</i>								



DIVISION OF VITAL RECORDS

BALTIMORE, MARYLAND 21215-0020

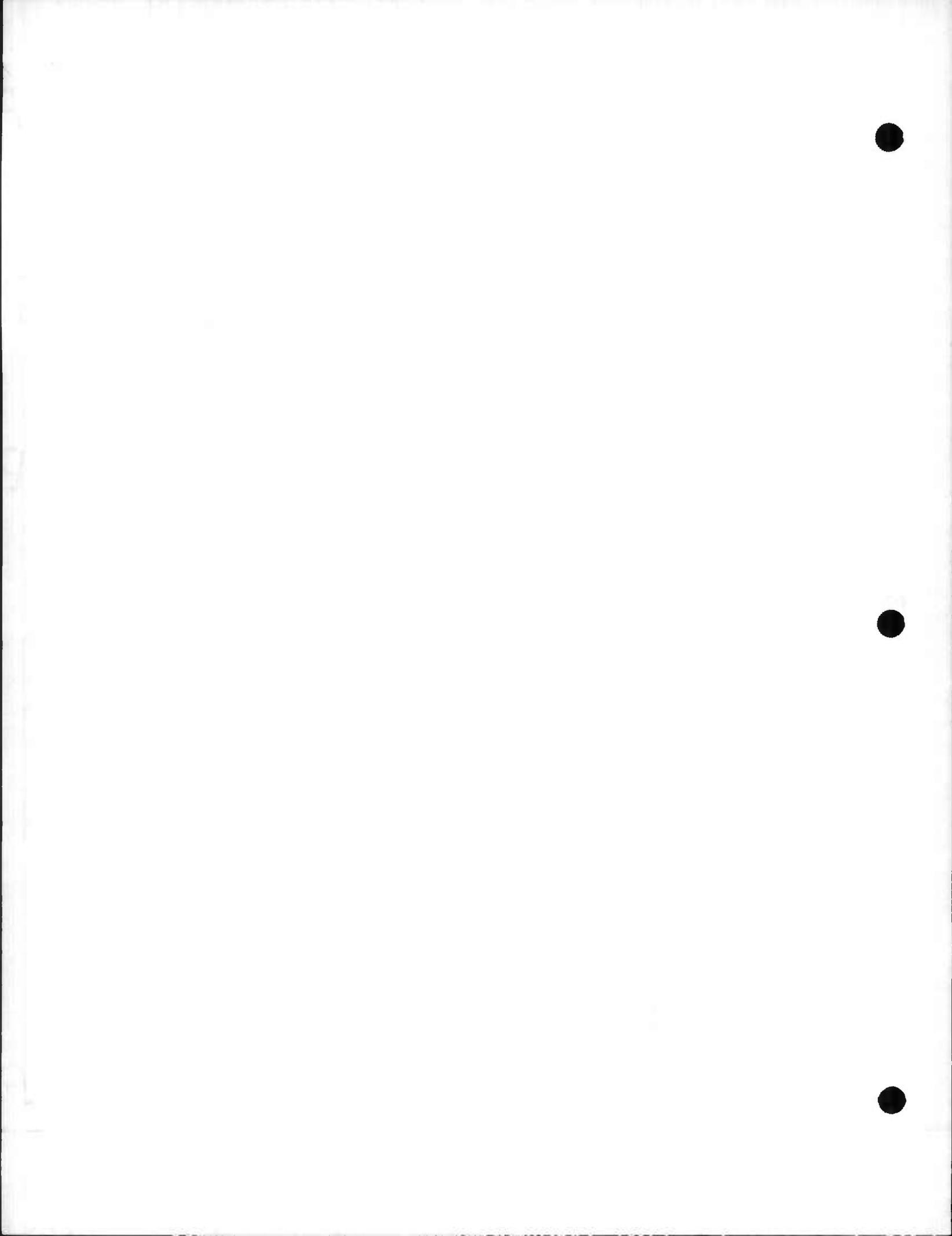


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) Adeline H. BICKLING												2. DATE OF DEATH MONTH DAY YEAR May 23 1995	3. TIME OF DEATH 11:20 p m	
4. SOCIAL SECURITY NUMBER 214-10-0434		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Nov. 23, 1919	8. BIRTHPLACE (State or Foreign Country) Maryland							
8a. FACILITY NAME (If not institution, give street and number) Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Easton			9c. COUNTY OF DEATH Talbot					
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10a. STATE Maryland	10b. COUNTY Caroline	10c. CITY, TOWN OR LOCATION Greensboro			10f. ZIP CODE 21639			10g. CITIZEN OF WHAT COUNTRY? U.S.A.						
10e. STREET AND NUMBER 106 Gramby Street														
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) line work			16b. KIND OF BUSINESS/INDUSTRY Swift & Company									
17. FATHER'S NAME (First, Middle, Last) Earl Holsinger						18. MOTHER'S NAME (First, Middle, Maiden Surname) Annice Rairigh Holsinger								
19a. INFORMANT'S NAME (Type/Print) Doris Harris		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 111 N. 10th Str., Denton, MD 21629												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greensboro Cemetery			DATE 5/27	20c. LOCATION — City or Town, State Greensboro, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Fleegle-Helfenbein Funeral Home P.O. Box 160 Greensboro, MD 21639										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Stroke</i>												Approximate Interval Between Onset and Death 11 days		
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST														
b. DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER DO1225			29d. DATE SIGNED (Month, Day, Year) 5-24-95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Steve Carney, 509 Idlewild Ave., Easton, MD 21601														
31. DATE FILED (Month, Day, Year) MAY 31 95		32. REGISTRAR'S SIGNATURE 												



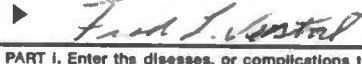
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)	Mildred Elizabeth BYRD											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 1:20 am M	
4. SOCIAL SECURITY NUMBER 214-09-3121		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Jan. 29, 1917		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 9710 Larkspur Lane				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown								9c. COUNTY OF DEATH Washington		
RESIDENCE OF DECEASED														
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 9710 Larkspur Lane				10f. ZIP CODE 21740								10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 0-8				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker				16b. KIND OF BUSINESS/INDUSTRY her own						
17. FATHER'S NAME (First, Middle, Last) Chester L. Burger				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rena Blenard										
19a. INFORMANT'S NAME (Type/Print) Mrs. Peggy Carroll				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9710 Larkspur Lane, Hagerstown, Maryland 21740										
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Rose Hill Cemetery				DATE 6-20-95		20c. LOCATION — City or Town, State Hagerstown, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 East Wilson Blvd., Hagerstown, MD 21740										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) → cancer Pancreas														
Approximate Interval Between Onset and Death 3 1/2 yrs														
b. DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.														
											24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
28e. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D18019			29d. DATE SIGNED (Month, Day, Year) JUN 19 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASTANT DATTA, MD 334 MILL ST HAGERSTOWN, MD 21740														
31. DATE FILED (Month, Day, Year) JUN 19 1995		32. REGISTRAR'S SIGNATURE 												

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DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

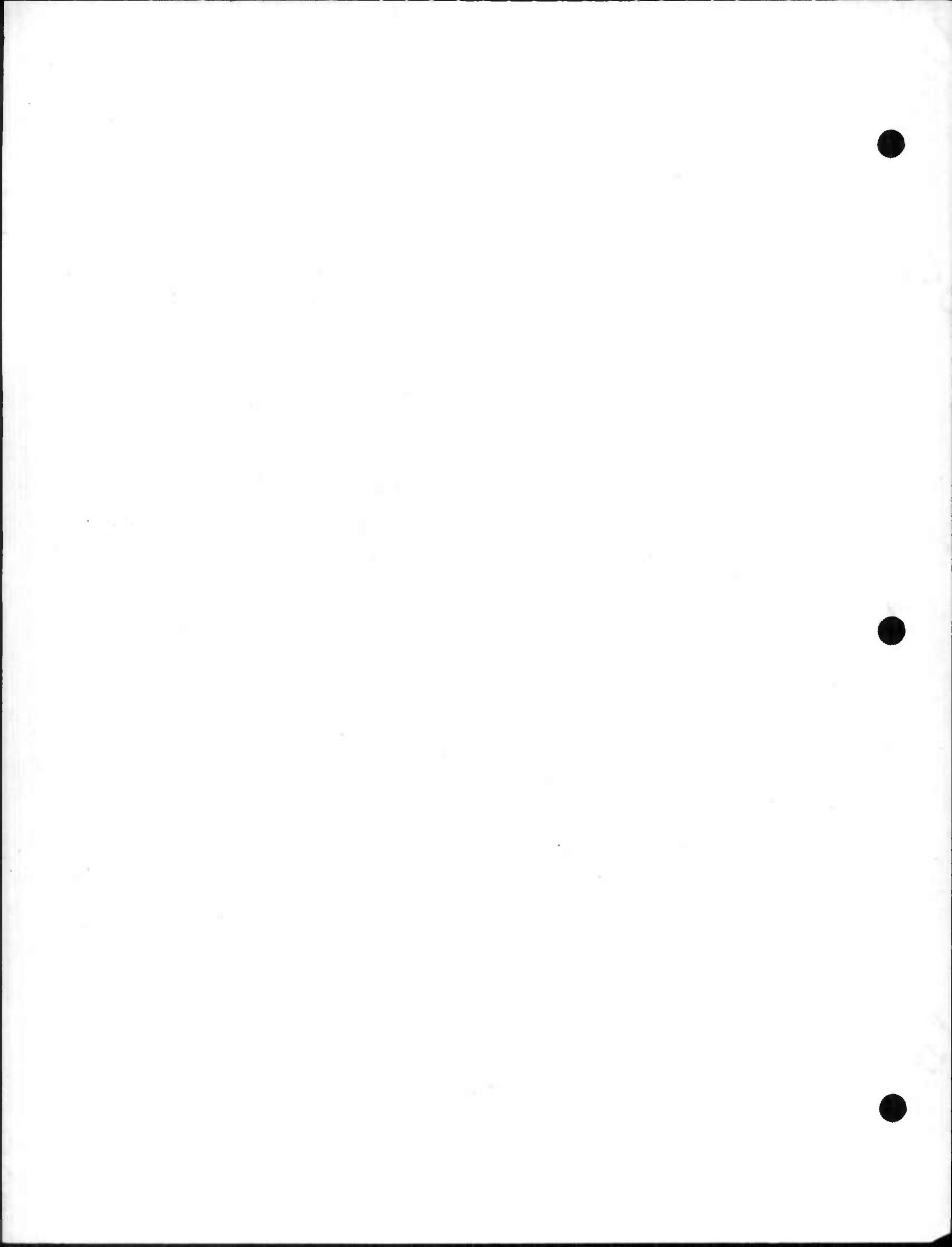
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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last)		Elsie Lorraine Bitner								2. DATE OF DEATH MONTH JUNE DAY 15 YEAR 1995	3. TIME OF DEATH 0046 M				
4. SOCIAL SECURITY NUMBER 219- 20- 1349		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) August 16, 1926		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number)		Washington County Hospital								9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Fairplay								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 17926 Lappans Rd.		10f. ZIP CODE 21733								10g. CITIZEN OF WHAT COUNTRY? U. S. A.					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES								13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker								16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Fred T. Avey												18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie M. Forrest			
19a. INFORMANT'S NAME (Type/Print) Stephen M. Bitner		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17926 Lappans Rd. FAirplay, Maryland 21733													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) St. Mark's Cemetery								DATE 6-17-95		20c. LOCATION — City or Town, State Lappans, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY BAST FUNERAL HOME, 7606 Old National Pike Boonsboro, Md. 21713													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 2 days			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Massive Left hemisphere stroke with edema and Brainstem herniation DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. _____ DUE TO (OR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):		d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 004359								29d. DATE SIGNED (Month, Day, Year) ► 6/15/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 22) (Type, Print) Robert Brull 1459 Potomac Ave., Hagerstown															
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE 													



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

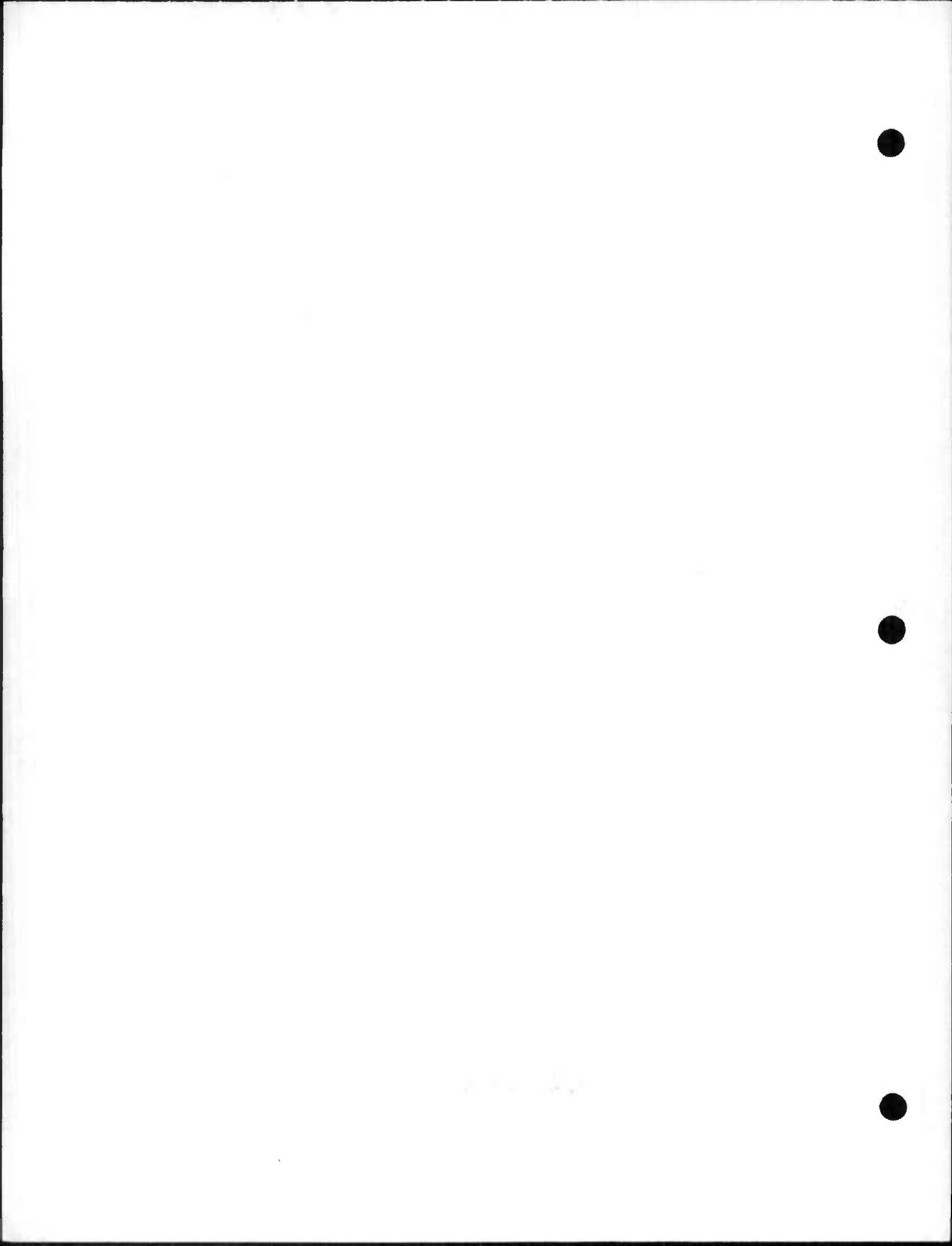
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH HOUR MIN.	
1. DECEDENT'S NAME (First, Middle, Last) WILLIAM ROGERS										BRADFORD	
4. SOCIAL SECURITY NUMBER 214-10-7956		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) June 26, 1912		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not Institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER										9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO											
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Wicomico	10c. CITY, TOWN OR LOCATION Salisbury								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 920 Riverside Dr.					10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Accountant			16b. KIND OF BUSINESS/INDUSTRY Power Co.						
17. FATHER'S NAME (First, Middle, Last) Edward Bradford					18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma (Unknown)						
19a. INFORMANT'S NAME (Type/Print) Linda B. Bromley					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1230 Terrill Rd., Scotch Plains, NJ 07076						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory			DATE 6/12		20c. LOCATION — City or Town, State Salisbury, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Holloway</i>		22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF): acute pneumonia, pneumonia possible congestive heart failure											
Approximate Interval Between Onset and Death 30 min											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Diseases or injury that initiated events resulting in death) LAST { b. c. d.											
DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. acute pneumonia, pneumonia possible congestive heart failure											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 15384		29d. DATE SIGNED (Month, Day, Year) ► 6/10/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RODNEY A. WENRICH		31. DATE FILED (Month, Day, Year) JUN 12 1995									
32. REGISTRAR'S SIGNATURE <i>John Wilson Harrell</i>											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

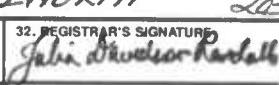
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

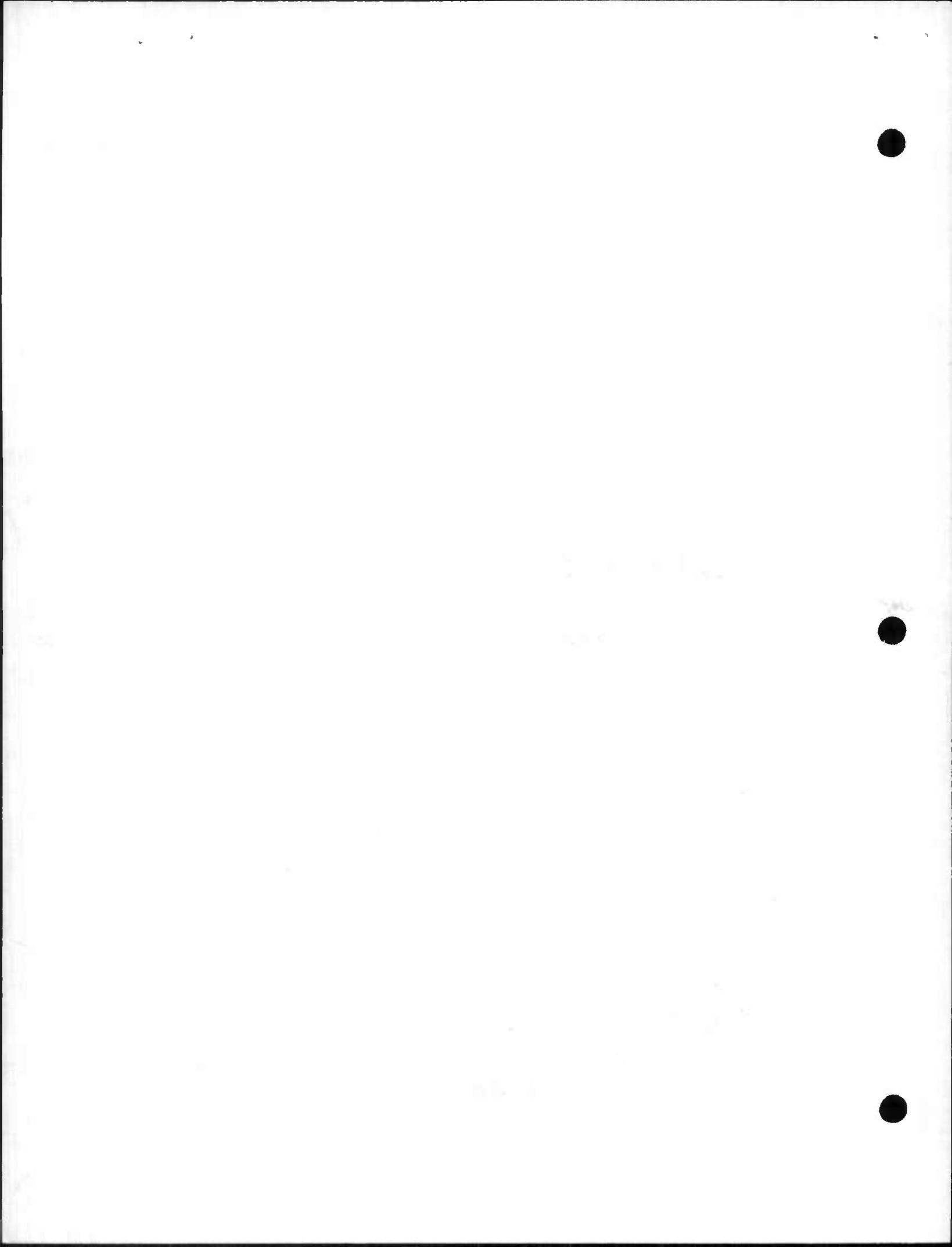
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH HRS. MIN.			
1. DECEDENT'S NAME (First, Middle, Last) Hortense Watson Bowen										5/7/1906	Delaware		
4. SOCIAL SECURITY NUMBER 216-64-8499		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 5/7/1906		8. BIRTHPLACE (State or Foreign Country) Worcester			
9a. FACILITY NAME (If not institution, give street and number) 9801 Deer Park Drive					9b. CITY, TOWN OR LOCATION OF DEATH Berlin					9c. COUNTY OF DEATH Worcester			
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Worcester	10c. CITY, TOWN OR LOCATION Bishopville								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 12444 Collins Road					10f. ZIP CODE 21813					10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:					14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) homemaker				16b. KIND OF BUSINESS/INDUSTRY ---					
17. FATHER'S NAME (First, Middle, Last) Pashur W. Watson Sr.					18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Belle Hall								
19a. INFORMANT'S NAME (Type/Print) Paul Mumford					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12444 Collins Rd., Bishopville, Md. 21813								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Redmen's Cemetery					DATE 6/11	20c. LOCATION — City or Town, State Selbyville, Delaware		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Watson Funeral Home, Millsboro, Del.								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death SEVERAL YES	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. ALZHEIMER'S DISEASE DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		{ b. _____ c. _____ d. _____ e. _____ f. _____ g. _____ h. _____ i. _____ j. _____ k. _____ l. _____ m. _____ n. _____ o. _____ p. _____ q. _____ r. _____ s. _____ t. _____ u. _____ v. _____ w. _____ x. _____ y. _____ z. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. INANITION												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24c. LOCATION (Street and Number or Rural Route Number, City or Town, State) CARETAKING HOME	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER J06241										29d. DATE SIGNED (Month, Day, Year) ► 6-9-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DOROTHY C. HOLZWORTH		32. REGISTRAR'S SIGNATURE 											
31. DATE FILED (Month, Day, Year) JUN 12 1995													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

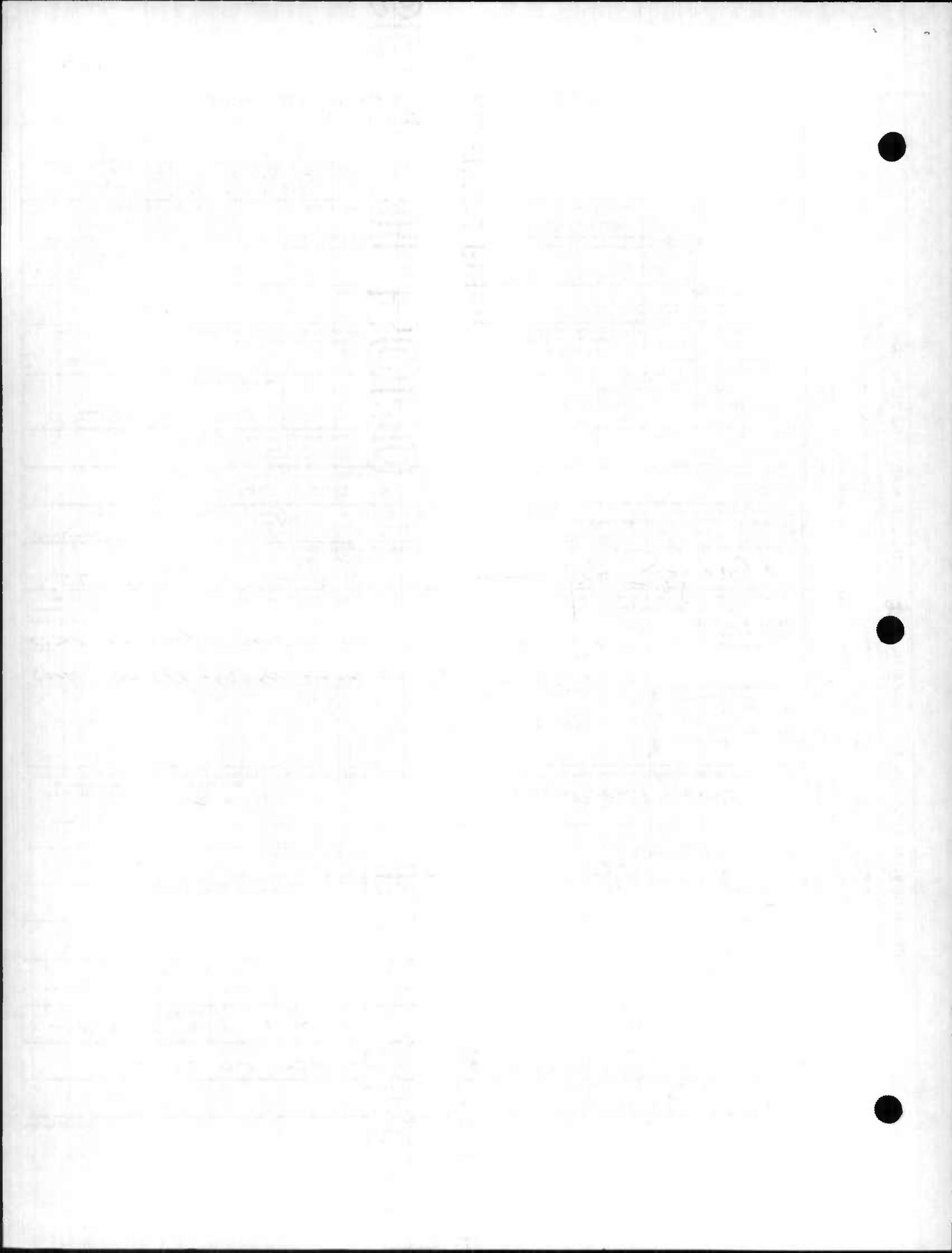
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19434

1. DECEDENT'S NAME (First, Middle, Last)		Joseph Howard Brown		2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 578-18-0246		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
9e. FACILITY NAME (If not institution, give street and number) Golden Oaks Convalescent Center		9b. CITY, TOWN OR LOCATION OF DEATH Laurel		7. DATE OF BIRTH (Month, Day, Year) Feb. 28, 1905	8. BIRTHPLACE (State or Foreign Country) Maryland
10e. STATE Maryland		10b. COUNTY Howard		9c. COUNTY OF DEATH Prince George	
10e. STREET AND NUMBER 12 Frances Street		10c. CITY, TOWN OR LOCATION Laurel		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: XX	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Grade 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist		16b. KIND OF BUSINESS/INDUSTRY Cookie Manufacturer	
17. FATHER'S NAME (First, Middle, Last) Howard Brown		18a. INFORMANT'S NAME (Type/Print) Charles Brown		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 206 Laurel, Maryland 20725	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory, or Other Place) Baltimore Cemetery		6722/1 95	20c. LOCATION — City or Town, State Scaggsville, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Gray S. K.</i>				22. NAME AND ADDRESS OF FACILITY Donaldson Funeral Home P.A. 313 Talbott Avenue Laurel, Md. 20707	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>a. <i>Prostate Disease Myocardial Infarction</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>ASCO & coronary Artery Disease</i> 725. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>					
Approximate Interval Between Onset and Death					
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p><i>CVA, Hypertension</i></p>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 025-422		29d. DATE SIGNED (Month, Day, Year) ► 6/19/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>R. M. Brown, MD</i>					
31. DATE FILED (Month, Day, Year) JUN 20 1995		32. REGISTRAR'S SIGNATURE <i>Juliann DeLoach-Parkall</i>			



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

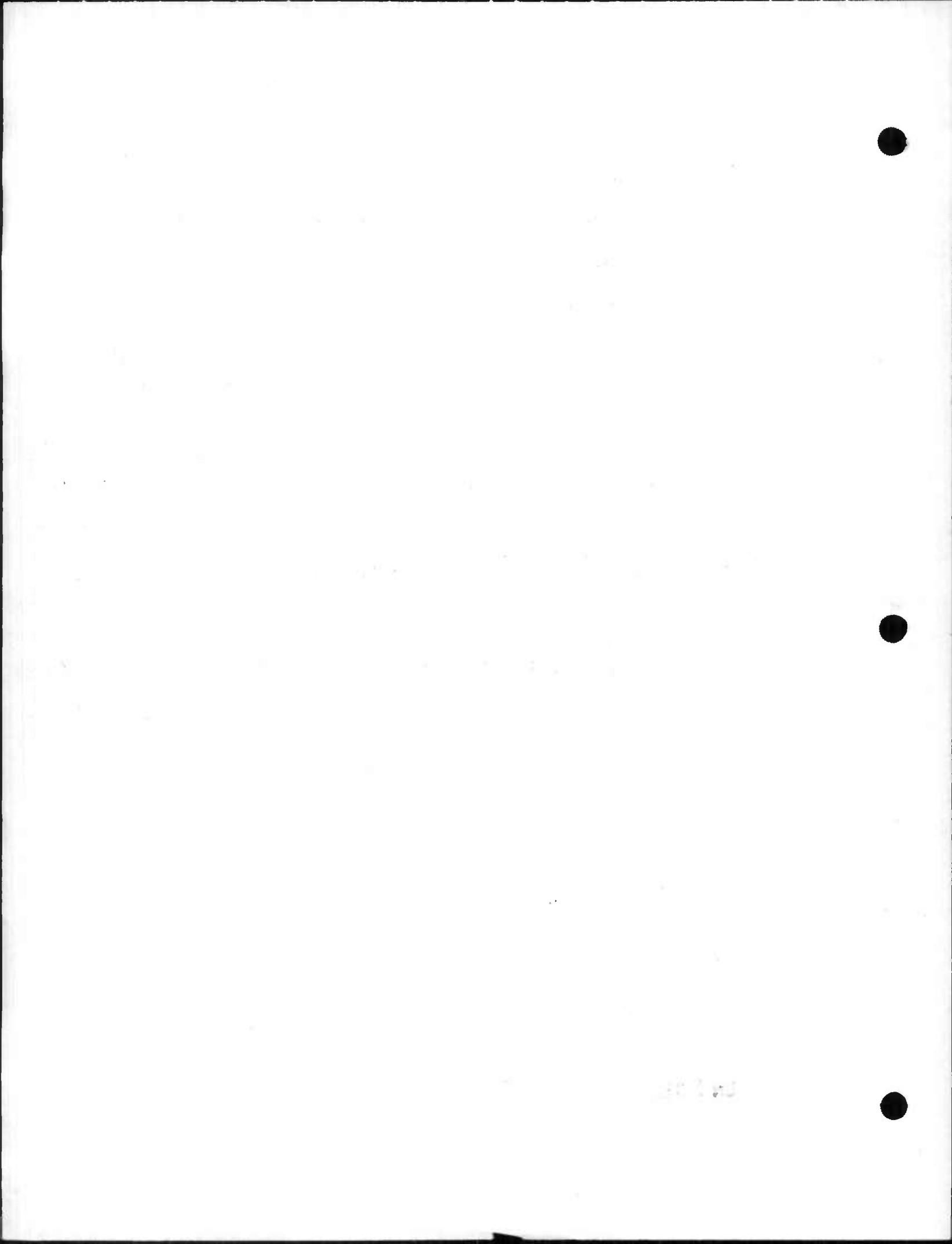
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last) Wilbur Ronald BUCKLEY		2. DATE OF DEATH MONTH June DAY 11 YEAR 1995					3. TIME OF DEATH 1225 PM							
4. SOCIAL SECURITY NUMBER 212-20-3556		5. SEX 1X M 2 F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) July 11, 1923		8. BIRTHPLACE (State or Foreign Country) West Virginia				
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown					9c. COUNTY OF DEATH Washington							
RESIDENCE OF DECEDENT														
10e. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown					10d. INSIDE CITY LIMITS? 1 X YES 2 NO							
10e. STREET AND NUMBER 256 South Potomac Street				10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II			13. WAS DECEDENT OF NARVICAN ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: white			14. RACE — American Indian, Black, White, etc.						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) shop steward			16b. KIND OF BUSINESS/INDUSTRY truck manufacturing									
17. FATHER'S NAME (First, Middle, Last) William V. Buckley				18. MOTHER'S NAME (First, Middle, Maiden Surname) Myrtle Mooney										
19a. INFORMANT'S NAME (Type/Print) Marietta Buckley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7404 Englewood Pl.#3, Annandale, Va. 22003										
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Cedar Lawn Memorial Park			DATE 6-14-95	20c. LOCATION — City or Town, State Hagerstown, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnich				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME										
				415 E. Wilson Blvd., Hagerstown, Md. 21740										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.														
IMMEDIATE CAUSE (Final disease or condition resulting in death) →														
a. LIVER CIRRHOSIS. DUE TO (OR AS A CONSEQUENCE OF):														
b. HEPATO RENAL SYNDROME. DUE TO (OR AS A CONSEQUENCE OF):														
c. X DUE TO (OR AS A CONSEQUENCE OF): X														
d. 														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. N/A														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide				28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED N/A		28e. PLACE OF INJURY — At home, farm, street, factory, office N/A				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) M. J. Shaf, M.D. 368 Mill St. Hagerstown, Md. 21740				31. DATE FILED (Month, Day, Year) JUN 1 31995				32. REGISTRAR'S SIGNATURE Jeanne Jackson-Kordell		33. LICENSE NUMBER D293 65			34. DATE SIGNED (Month, Day, Year) ► 6.12.95	



FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
Harry Clayton Beard, JCERTIFICATE OF DEATH

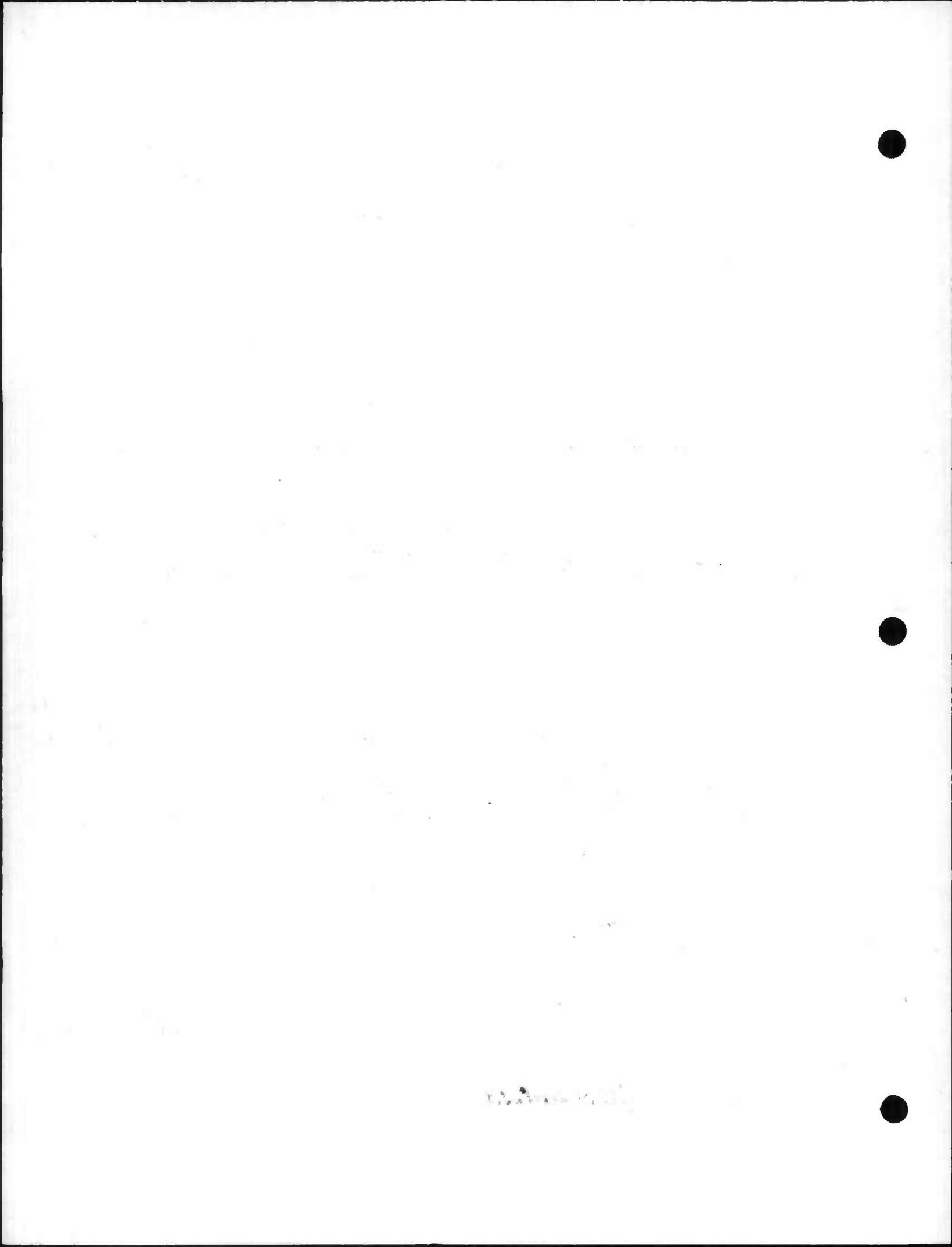
REG. NO.

1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH 6 DAY 11 YEAR 95				3. TIME OF DEATH 12:10 p.m.		
Harry Clayton Beard		4. SOCIAL SECURITY NUMBER 215-20-9095	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) 65 6 YRS.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Aug. 29, 1929	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington		
Washington County Hospital								
RESIDENCE OF DECEASED								
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Funkstown				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 200 Chestnut Street Apt. 9		10f. ZIP CODE 21734				10g. CITIZEN OF WHAT COUNTRY? USA		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11	16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY general duties			Grocery Retail	
17. FATHER'S NAME (First, Middle, Last) Harry Clayton Beard, Sr.		18. MOTHER'S NAME (First, Middle, Maiden Surname) Lutie Seavers Frankenberry						
19a. INFORMANT'S NAME (Type/Print) Pamela Harr		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1023 Spruce Street Hagerstown, Maryland 21740						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery				DATE 6/14	20c. LOCATION — City or Town, State Hagerstown, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>		22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich Funeral Home				305 N. Potomac Street Hagerstown, Maryland		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <u>Cerebrovascular accident</u> DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death 2 weeks
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <u>Arteriosclerotic Cerebrovascular disease</u> DUE TO (OR AS A CONSEQUENCE OF):						8 years
{		c. <u>Obliterative Peripheral Vessel disease</u> DUE TO (OR AS A CONSEQUENCE OF):						10 years
		d. <u>Diabetes mellitus, Type II</u>						15 years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Chronic Bronchitis of cigarette users</u> <u>Chronic obstructive Pulmonary Disease</u>								
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Brull MD Personal Physician</i>		29c. LICENSE NUMBER 004359		29d. DATE SIGNED (Month, Day, Year) 6/11/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Brull MD 1459 Potomac Ave. Hagerstown</i>								
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Susan Brull</i>						

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

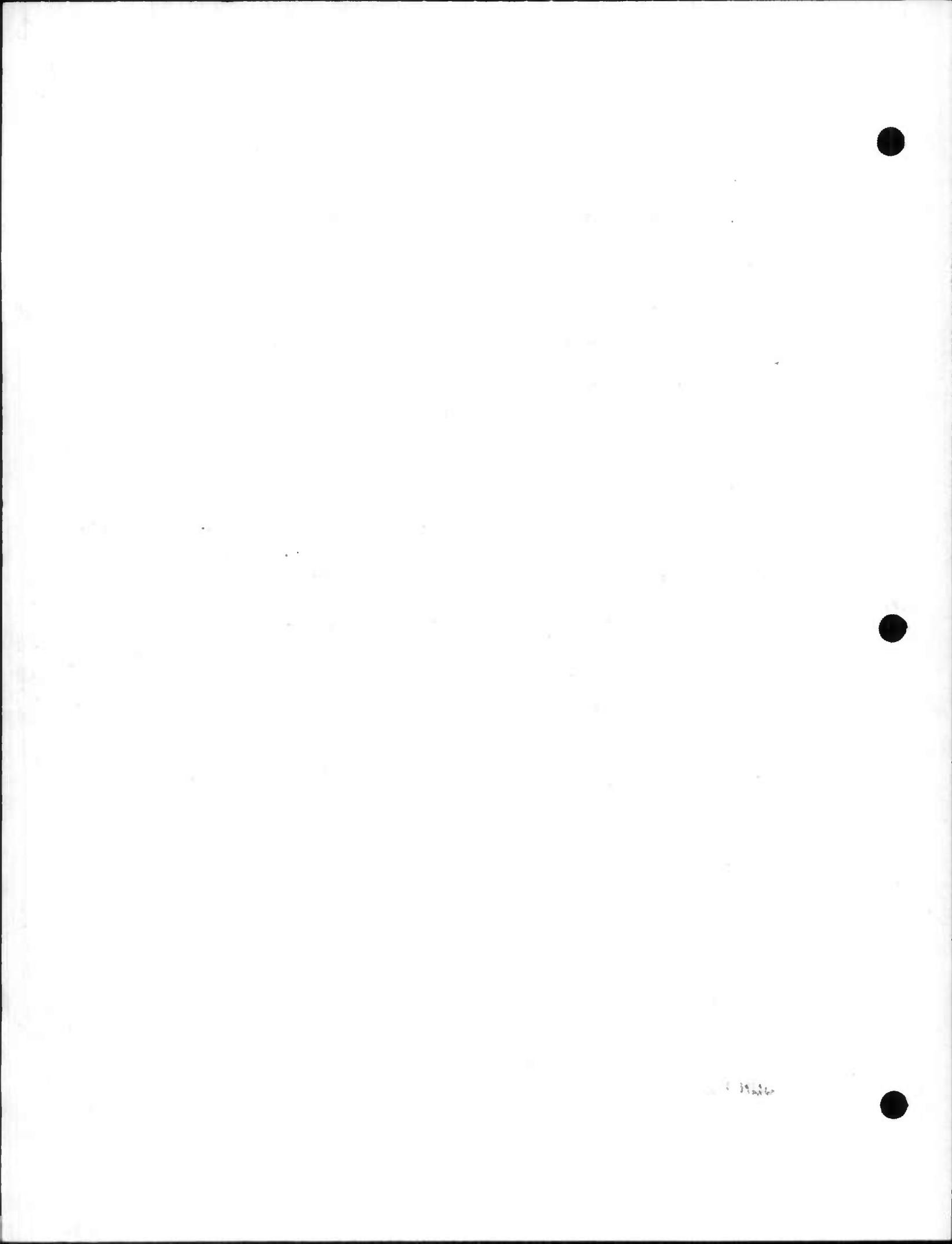
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Michael John Bellon												2. DATE OF DEATH MONTH JUNE DAY 10 YEAR 95	3. TIME OF DEATH 1345 M		
4. SOCIAL SECURITY NUMBER 140 09 4037		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF HOURS 0	IF MIN. 0	7. DATE OF BIRTH (Month, Day, Year) March 28, 1907	8. BIRTHPLACE (State or Foreign Country) Czechoslovakia						
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown				9c. COUNTY OF DEATH Washington							
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STATE Maryland	10f. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown				10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? USA					
10e. STREET AND NUMBER 19519 Foxcroft Drive				10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) machinist		16b. KIND OF BUSINESS/INDUSTRY Mack Trucks, Inc.											
17. FATHER'S NAME (First, Middle, Last) John Bellon				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Anna Kanich											
19e. INFORMANT'S NAME (Type/Print) Nancy E. Bellon				19d. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 300 Franklin Street Middletown, Maryland 21769											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) Smithsburg Crematory				DATE 6/11	20c. LOCATION — City or Town, State Smithsburg, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Gerald N. Minnich				22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich Funeral Home				305 N. Potomac Street Hagerstown, Maryland							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mods of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Pneumonia DUE TO (OR AS A CONSEQUENCE OF): c. Carcinoma of the Lung DUE TO (OR AS A CONSEQUENCE OF): d.												24 hours			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												48 hours			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic Obstructive Pulmonary Disease												2 months			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) M		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED									
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D 30757										29d. DATE SIGNED (Month, Day, Year) ► 06/10/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) George Way, M. D. 265 Mill Street Hagerstown, Maryland 21740												31. DATE FILED (Month, Day, Year) JUN 13 1995			32. REGISTRAR'S SIGNATURE Susan Randall



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

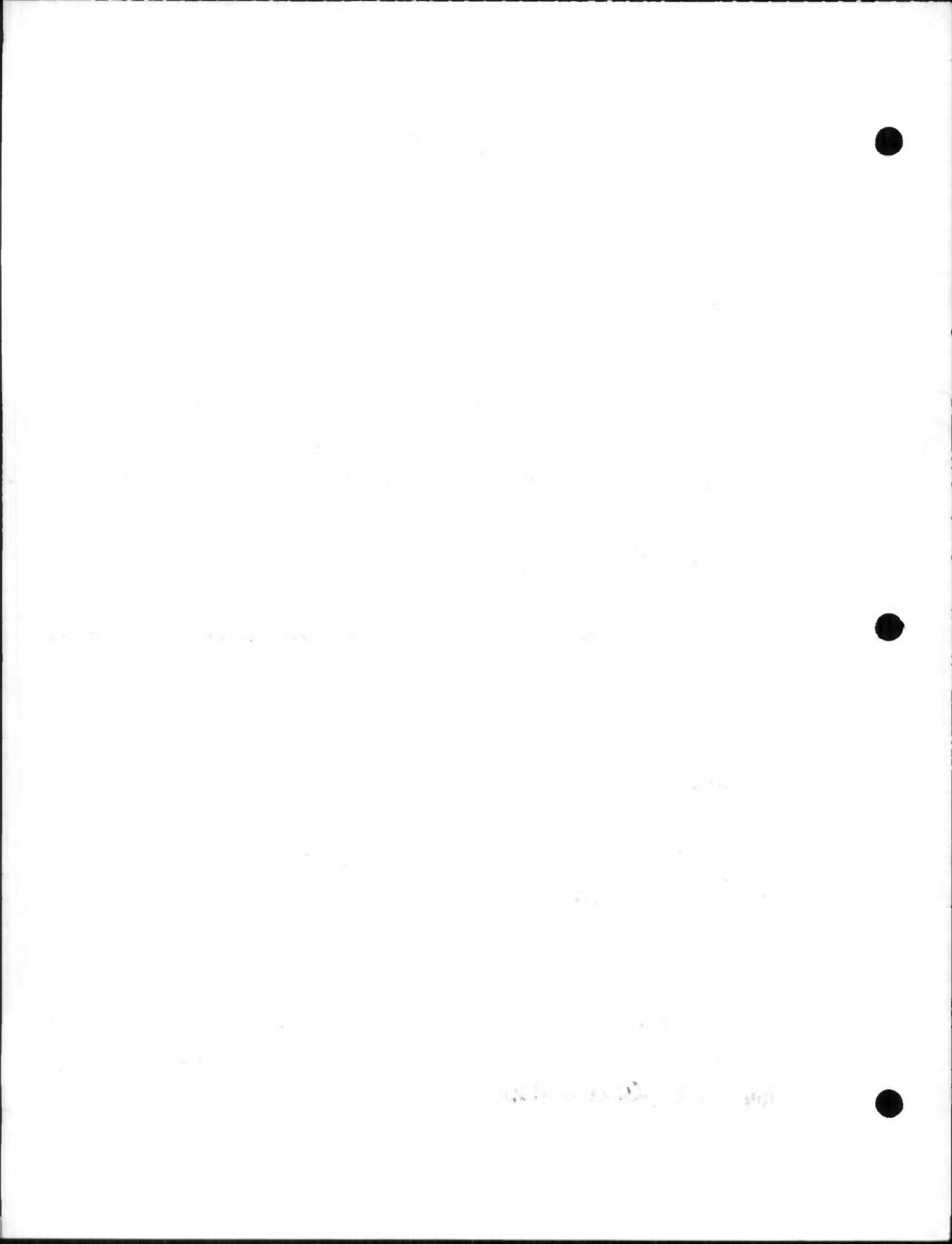
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - FOR STATE REGISTRAR		Glenn Christian BRECHBILL								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
1. DECEDENT'S NAME (First, Middle, Last)										June 8, 1995	2:30 A M		
4. SOCIAL SECURITY NUMBER 214-30-1893		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 61 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) July 22, 1933		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) 14916 Bottom Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Williamsport								9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT													
10e. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Williamsport								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 14916 Bottom Rd.		10f. ZIP CODE 21795								10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPAHIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor				16b. KIND OF BUSINESS/INDUSTRY W.D. Byron Tannery							
17. FATHER'S NAME (First, Middle, Last) Glenn Russell Brechbill		18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Geraldine Moats											
19a. INFORMANT'S NAME (Type/Print) Doris Jean Snyder Brechbill		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14916 Bottom Rd. Williamsport, MD. 21795											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of funeral home or cemetery or other place) GREENLAWN MEMORIAL PARK				DATE June 10, 1995		20c. LOCATION — City or Town, State Williamsport, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY OSBORNE FUNERAL HOME P.O.BOX 348								WILLIAMSPORT, MD 21795			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death YEARS	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. CHRONIC OBSTRUCTIVE PULMONARY DISEASE DUE TO (OR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ c. _____ d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Note												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year) NONE				26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER DO1040								29d. DATE SIGNED (Month, Day, Year) ► 06-08-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Barry M. Cohen 18706 Crestwood Dr. Hagerstown, MD. 21742													
31. DATE FILED (Month, Day, Year) JUN 8 1995		32. REGISTRAR'S SIGNATURE 											



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 8, 1995										3. TIME OF DEATH 9:30 P.M.	
1. DECEDENT'S NAME (First, Middle, Last) Pamelia Niles BEAN												7. DATE OF BIRTH (Month, Day, Year) May 16, 1922	8. BIRTHPLACE (State or Foreign Country) Ohio
4. SOCIAL SECURITY NUMBER 256-38-4754		5. SEX <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		9a. FACILITY NAME (If not institution, give street and number) 13236 Club Road		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown											
10e. STREET AND NUMBER 13236 Club Road				10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: white				14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) case worker				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) William Perry Earlie						18. MOTHER'S NAME (First, Middle, Maiden Surname) Fredericka M. Niles							
19a. INFORMANT'S NAME (Type/Print) Barbara Bean Miller						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13236 Club Road, Hagerstown, Maryland 21740							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 6-9-95				20c. LOCATION — City or Town, State Hagerstown, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnick												22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. <i>Cardiorespiratory arrest immediate</i> DUE TO (OR AS A CONSEQUENCE OF):													
b. <i>Alzheimer disease</i> DUE TO (OR AS A CONSEQUENCE OF):													
c. <i>osteophytes</i> DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>At home</i>											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Niles B. Bean</i>						29c. LICENSE NUMBER 14800				29d. DATE SIGNED (Month, Day, Year) ► 6/9/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MASSOUD B. ALRAADEH, MD 240 Frederick St													
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

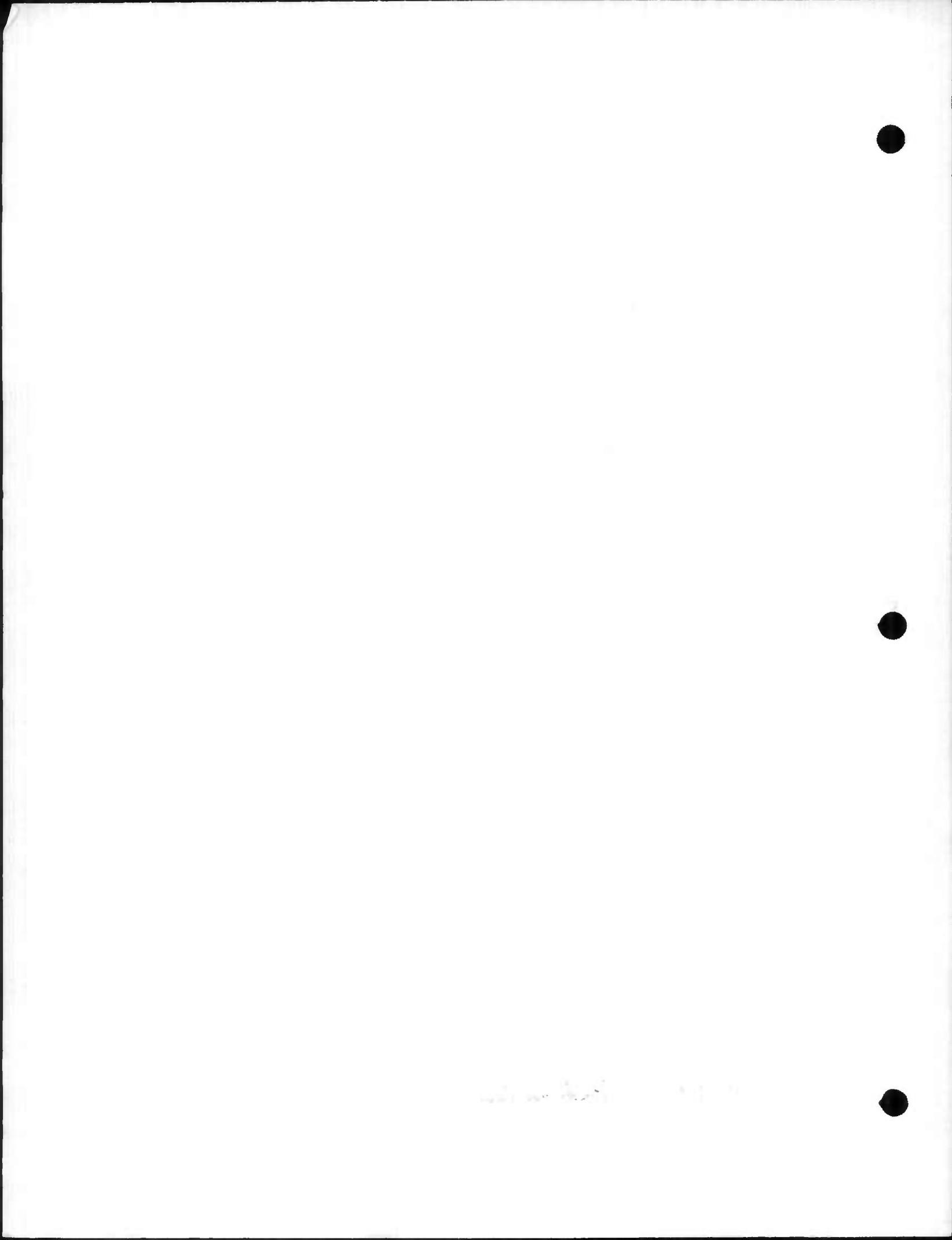
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.								
1. DECEDENT'S NAME (First, Middle, Last)		DOROTHY ELIZABETH BAKER								2. DATE OF DEATH MONTH 6 DAY 9 YEAR 95 2016		3. TIME OF DEATH M								
4. SOCIAL SECURITY NUMBER 215-14-1072		S. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	8. AGE (In yrs. last birthday) 72 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 11-19-1922		8. BIRTHPLACE (State or Foreign Country) Maryland										
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown								9c. COUNTY OF DEATH Washington										
RESIDENCE OF DECEDENT																				
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO										
10e. STREET AND NUMBER 1040 Fairview Road				10f. ZIP CODE 21742				10g. CITIZEN OF WHAT COUNTRY? U.S.A.												
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White												
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Personal Residence															
17. FATHER'S NAME (First, Middle, Last) Paul Harbaugh Brown				18. MOTHER'S NAME (First, Middle, Maiden Surname) Belva Ruth Finneyfrock																
19a. INFORMANT'S NAME (Type/Print) Joseph Curtis Baker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1040 Fairview Road Hagerstown, Maryland 21742																
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rest Haven Cemetery June 13, 1995				DATE		20c. LOCATION — City or Town, State Hagerstown, Maryland										
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Douglas A. Fiery Funeral Home 1331 Eastern Blvd. North Hagerstown, Md.																
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																				
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																				
<p>a. acute ventricular septal rupture 36 hrs DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. acute inferior wall myocardial infarct DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p>																				
Approximate Interval Between Onset and Death																				
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																				
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO																				
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																				
27. MANNER OF DEATH <table border="0"> <tr> <td><input checked="" type="checkbox"/> Natural</td> <td><input type="checkbox"/> Pending investigation</td> </tr> <tr> <td><input type="checkbox"/> Accident</td> <td></td> </tr> <tr> <td><input type="checkbox"/> Suicide</td> <td><input type="checkbox"/> Could not be determined</td> </tr> <tr> <td><input type="checkbox"/> Homicide</td> <td></td> </tr> </table>													<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation	<input type="checkbox"/> Accident		<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined	<input type="checkbox"/> Homicide	
<input checked="" type="checkbox"/> Natural	<input type="checkbox"/> Pending investigation																			
<input type="checkbox"/> Accident																				
<input type="checkbox"/> Suicide	<input type="checkbox"/> Could not be determined																			
<input type="checkbox"/> Homicide																				
<p>28a. DATE OF INJURY (Month, Day, Year)</p> <p>28b. TIME OF INJURY M</p> <p>28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>28d. DESCRIBE HOW INJURY OCCURRED</p> <p>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)</p> <p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)</p>																				
29e. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29f. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																				
29g. SIGNATURE AND TITLE OF CERTIFIER 				29h. LICENSE NUMBER 072851				29i. DATE SIGNED (Month, Day, Year) ► 6/9/95												
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Gary C. Panchis 354 Mill Street Hagerstown, Maryland 21740																				
31. DATE FILED (Month, Day, Year) JUN 12 1995				32. REGISTRAR'S SIGNATURE 																



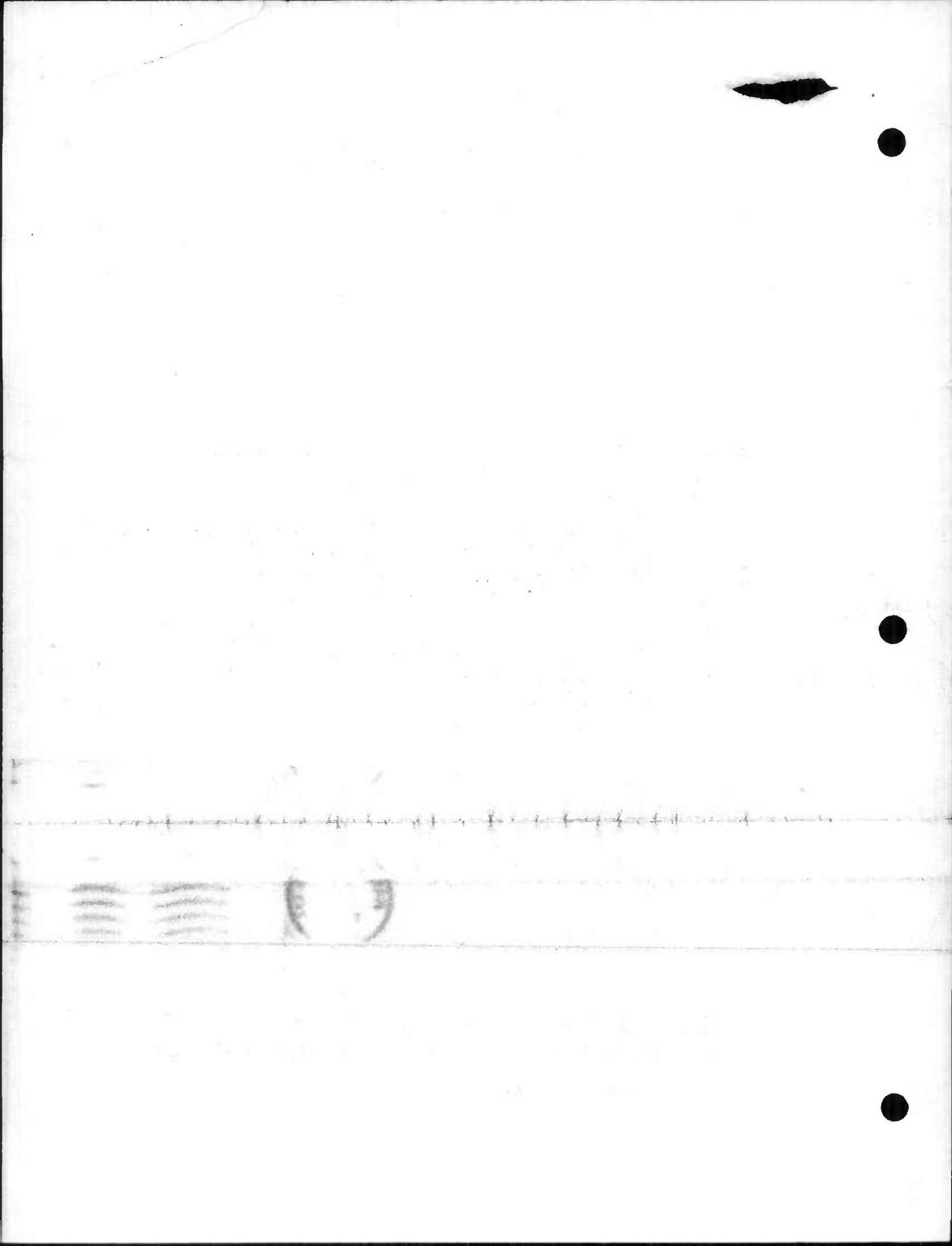
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If Item 23 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Mildred R. Bickley										2. DATE OF DEATH MONTH June DAY 8 YEAR 1995	3. TIME OF DEATH 12:05 PM
4. SOCIAL SECURITY NUMBER 195-07-3869		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0		IF UNDER 24 HRS. HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) March 21, 1907		8. BIRTHPLACE (State or Foreign Country) PA	
9a. FACILITY NAME (If not Institution, give street and number) Washington County General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown, MD				9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT											
10a. STATE PA	10b. COUNTY Cumberland		10c. CITY, TOWN OR LOCATION Lower Allen Twp.							10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 9 Cornell Drive				10f. ZIP CODE 17011				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: white			14. RACE — American Indian, Black, White, etc. Specify:			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Domestic						
17. FATHER'S NAME (First, Middle, Last) Augustus Smith					18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Wolfe						
19a. INFORMANT'S NAME (Type/Print) Lawrence S. Bickley				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9 Cornell Drive, Camp Hill, PA 17011							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Prospect Hill Cemetery				DATE 6/12/95	20c. LOCATION — City or Town, State Harrisburg, PA		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dwayne Shuhart MD				22. NAME AND ADDRESS OF FACILITY Snyder-Lochstampfor Funeral Home, Inc. 48 S. Church Street, Waynesboro, PA 17268							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
e. Cardiogenic Shock DUE TO (OR AS A CONSEQUENCE OF): Myocardial infarction											
Approximate Interval Between Onset and Death 3 hours											
b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
Approximate Interval Between Onset and Death 5 hours											
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Erosive esophagitis, Disseminated intravascular coagulopathy Hypertrophic Cardiomyopathy											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nonsuicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Dwayne Shuhart MD									
		29c. LICENSE NUMBER D45472									
		29d. DATE SIGNED (Month, Day, Year) ► June 8, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dwayne Shuhart MD Smithsburg Family Medical Center Smithsburg MD.											
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE Jahn Shuhart Bassett									



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last) Alvin Everhart BAKER			2. DATE OF DEATH MONTH DAY YEAR June 7, 1995									3. TIME OF DEATH 6:00 AM				
4. SOCIAL SECURITY NUMBER 214-09-0435		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 82 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			7. DATE OF BIRTH (Month, Day, Year) April 17, 1913		8. BIRTHPLACE (State or Foreign Country) Hagerstown, Md.					
9a. FACILITY NAME (If not institution, give street and number) 819 Maryland Avenue			9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown									9c. COUNTY OF DEATH Washington				
RESIDENCE OF DECEDENT																
10a. STATE Maryland	10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Hagerstown									10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 819 Maryland Avenue				10f. ZIP CODE 21740					10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 7			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: white			14. RACE — American Indian, Black, White, etc. Specify: white								
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (14 or 5+) 0 machinist			16b. KIND OF BUSINESS/INDUSTRY truckin											
17. FATHER'S NAME (First, Middle, Last) J. William Baker				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alvina Loudenslager												
19a. INFORMANT'S NAME (Type/Print) Hilda J. Baker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 819 Maryland Ave., Hagerstown, Maryland 21740												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Rose Hill Cemetery			DATE 6-10-95	20c. LOCATION — City or Town, State Hagerstown, Maryland								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnick				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME												
				415 E. Wilson Blvd., Hagerstown, Md. 21740												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →													Approximate Interval Between Onset and Death			
<p>a. <i>Cardiorespiratory failure</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Chronic bronchitis</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>metastatic carcinoma lung</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p>																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)										
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29c. LICENSE NUMBER 1012436										29d. DATE SIGNED (Month, Day, Year) ► 6-8-95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Richard O'Boyle MD 1825 Newell Rd Hagerstown																
31. DATE FILED (Month, Day, Year) JUN 8 1995			32. REGISTRAR SIGNATURE John L. Baker										DHMH-16 Rev 1/99			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

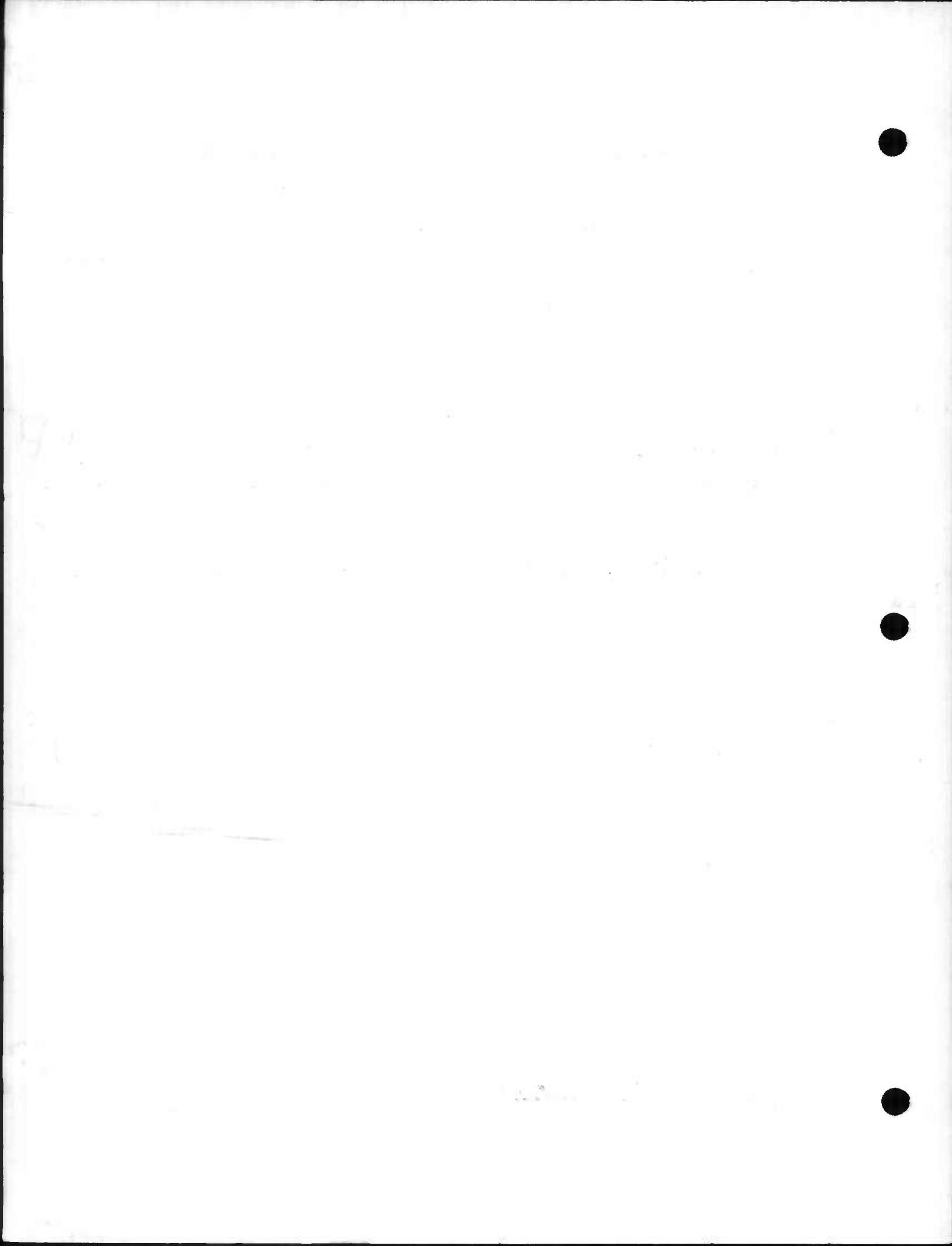
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Ella Mae Bingaman										2. DATE OF DEATH MONTH DAY YEAR June 7, 1995	3. TIME OF DEATH 2:01 p m
4. SOCIAL SECURITY NUMBER 174-01-3577		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Sept. 18, 1925	8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) Avalon Manor Home Inc.										9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	9c. COUNTY OF DEATH Washington
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 21521 Leitersburg-Smithsburg Road					10f. ZIP CODE 21742		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: white			14. RACE — American Indian, Black, White, etc.			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0			17. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Neal			18b. KIND OF BUSINESS/INDUSTRY her own home			
19a. INFORMANT'S NAME (Type/Print) Donna Bitner					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21521 Leitersburg-Smithsburg Rd., Hagerstown, Md.						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Hill Cemetery			DATE 6-10-95	20c. LOCATION — City or Town, State Waynesboro, Pennsylvania		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E.Wilson Blvd., Hagerstown, Md. 21740						
23. PART I. Enter the diseases, dr complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death few days	
<p>a. Cerebral metastasis DUE TO (OR AS A CONSEQUENCE OF): Carcinoma lung</p> <p>b. Carcinoma lung DUE TO (OR AS A CONSEQUENCE OF): Chronic obstructive pulmonary disease</p> <p>c. Chronic obstructive pulmonary disease DUE TO (OR AS A CONSEQUENCE OF): Cardiovascular accident</p> <p>d. Cardiovascular accident</p>										1 year	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Vasant Datta, MD					29c. LICENSE NUMBER D 18019			29d. DATE SIGNED (Month, Day, Year) June 7, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VASANT DATTA, MD 334 NCLL ST HAGERSTOWN MD 21740											
31. DATE FILED (Month, Day, Year) JUN 8 1995		32. REGISTRAR'S SIGNATURE 									



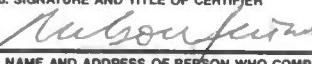
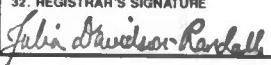
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

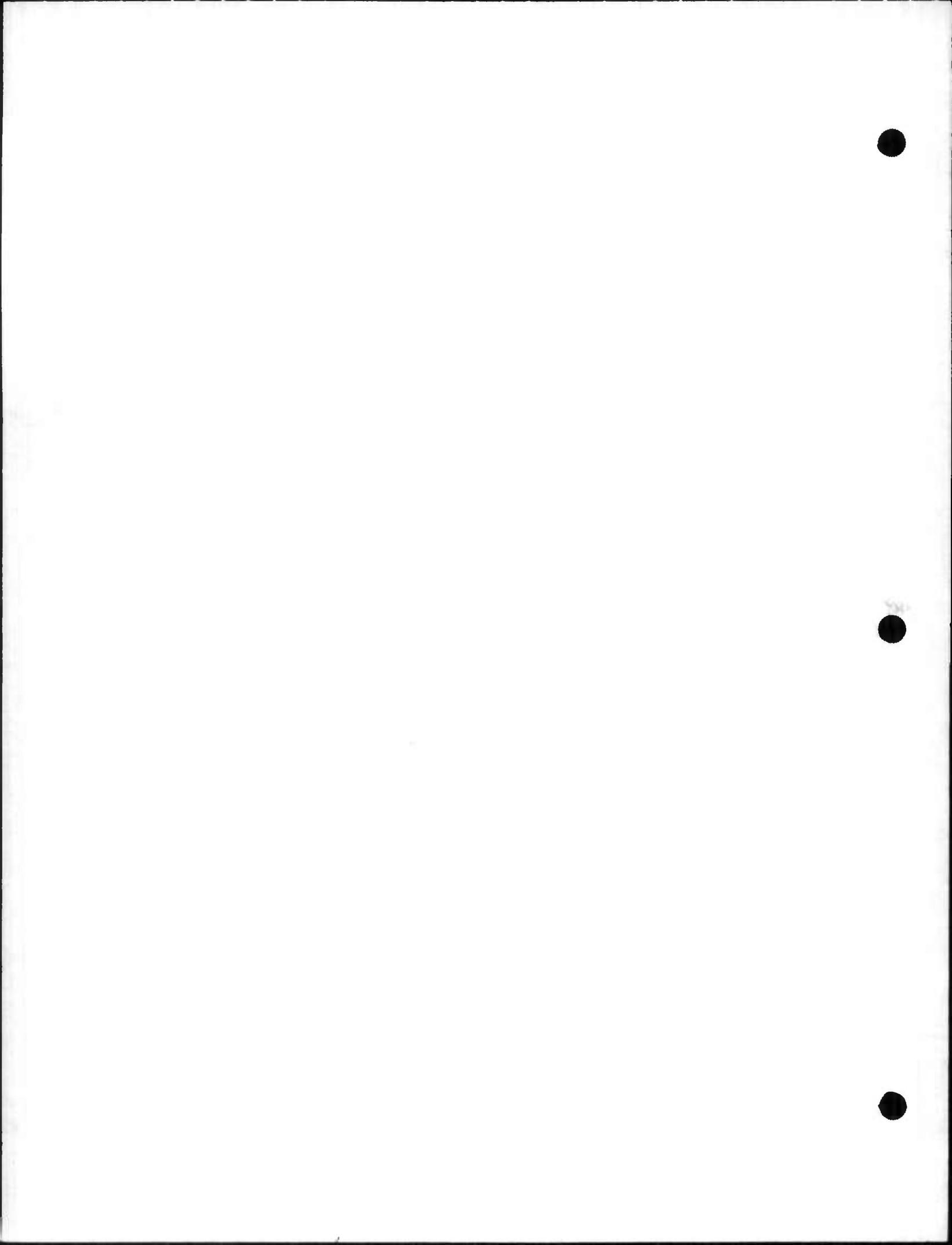
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) HELEN G. BODNER										2. DATE OF DEATH MONTH DAY YEAR JUNE 07 95	3. TIME OF DEATH YEAR HOUR MIN. 95 7:38 P M	
4. SOCIAL SECURITY NUMBER 579 32 2911		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) April 25, 1907			8. BIRTHPLACE (State or Foreign Country) New Jersey	
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON ADVENTIST HOSPITAL										9b. CITY, TOWN OR LOCATION OF DEATH TAKOMA PARK	9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEASED												
10a. STATE MD.	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION SILVER SPRING								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 8830 PINEY BRANCH RD.					10f. ZIP CODE 20903					10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY HOUSEWIFE							
17. FATHER'S NAME (First, Middle, Last) MICHAEL GALLA					18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH LEPTAK							
19a. INFORMANT'S NAME (Type/Print) DANIEL BODNER					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 180311 TARTER CANYON, GERING, NEB.					20c. LOCATION — City or Town, State Washington, d.c.		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SOI DTERS HOME CEMETERY			DATE June 13, 1995		20c. LOCATION — City or Town, State Washington, d.c.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY TAKOMA FUNERAL HOME INC 254 CARROLL ST. N.W. WASHINGTON, D.C. 20012		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death 1-2 yrs.		
a. AORTIC STENOSIS DUE TO (OR AS A CONSEQUENCE OF): PARKINSONIAN DISEASE												
b. DEMENTIA DUE TO (OR AS A CONSEQUENCE OF): HYPOTHYROIDISM										2+ yrs.		
c. DUE TO (OR AS A CONSEQUENCE OF):										2+ yrs.		
d. DUE TO (OR AS A CONSEQUENCE OF):												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPOTHYROIDISM										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 28d. DESCRIBE HOW INJURY OCCURED						
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29d. DATE SIGNED (Month, Day, Year) ► 6/9/95		
29b. SIGNATURE AND TITLE OF CERTIFIER  NELSON L. LUI, MD										29c. LICENSE NUMBER D43869		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 831 UNIVERSITY BLVD. EAST, SUITE 23, SILVER SPRING, MD 20903												
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE 										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

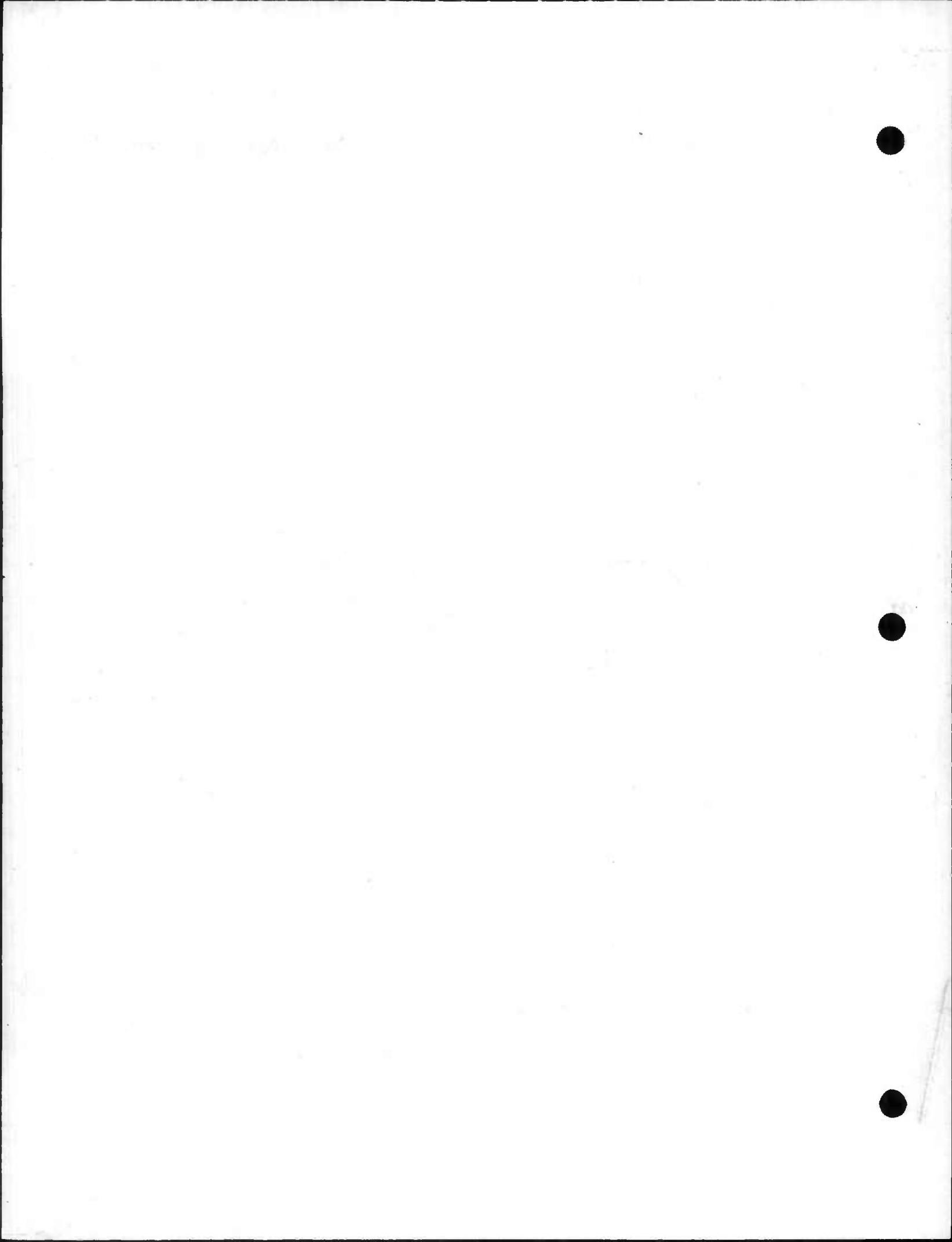
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) <i>Cecile D Bergeron</i>											2. DATE OF DEATH MONTH DAY YEAR June 9 1995	3. TIME OF DEATH YEAR 5:50 A.M.
4. SOCIAL SECURITY NUMBER 214-52-7406		5. SEX t <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 87 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 18, 1907		8. BIRTHPLACE (State or Foreign Country) Connecticut				
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT											10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Bethesda				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? United States				
10e. STREET AND NUMBER 9306 Adelaide Drive												
11. MARITAL STATUS t <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Teacher			16b. KIND OF BUSINESS/INDUSTRY Education							
College (1-4 or 5+) 2												
17. FATHER'S NAME (First, Middle, Last) Edouard Desaulniers					18. MOTHER'S NAME (First, Middle, Maiden Surname) Alma Paradis							
19a. INFORMANT'S NAME (Type/Print) Wilfred L. Bergeron					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9306 Adelaide Drive, Bethesda, Maryland 20817							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery			DATE June 12, 1995		20c. LOCATION — City or Town, State Silver Spring, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randy French</i>					22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Bethesda-Chevy Chase, Inc. 7557 Wisconsin Ave., Bethesda, MD 20814-3501							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →					Approximate Interval Between Onset and Death 48 hours							
a. <i>Aspiration Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):												
b. <i>Parkinson's Disease</i> DUE TO (OR AS A CONSEQUENCE OF):												
c. <i>Chronic</i> DUE TO (OR AS A CONSEQUENCE OF):												
d. <i></i>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Breast CANCER</i> <i>BRONCHITIS</i>											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? t <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			OTHER:							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
8 <input type="checkbox"/> Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Gloger, MD</i>					29c. LICENSE NUMBER 0 44580			29d. DATE SIGNED (Month, Day, Year) ► 6/9/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mark Gloger, MD, 9711 Medical Center Drive, #308, Rockville, MD 20850											OHMH-18 Rev 1/89	
31. DATE FILED (Month, Day, Year) JUN 12 1995					32. REGISTRAR'S SIGNATURE <i>Jeanne A. Jackson-Patterson</i>							



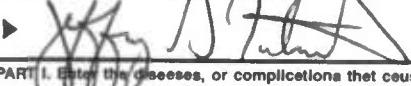
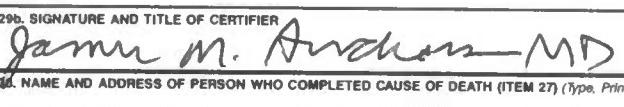
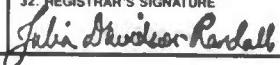
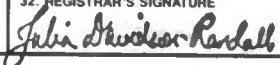
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be secured within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

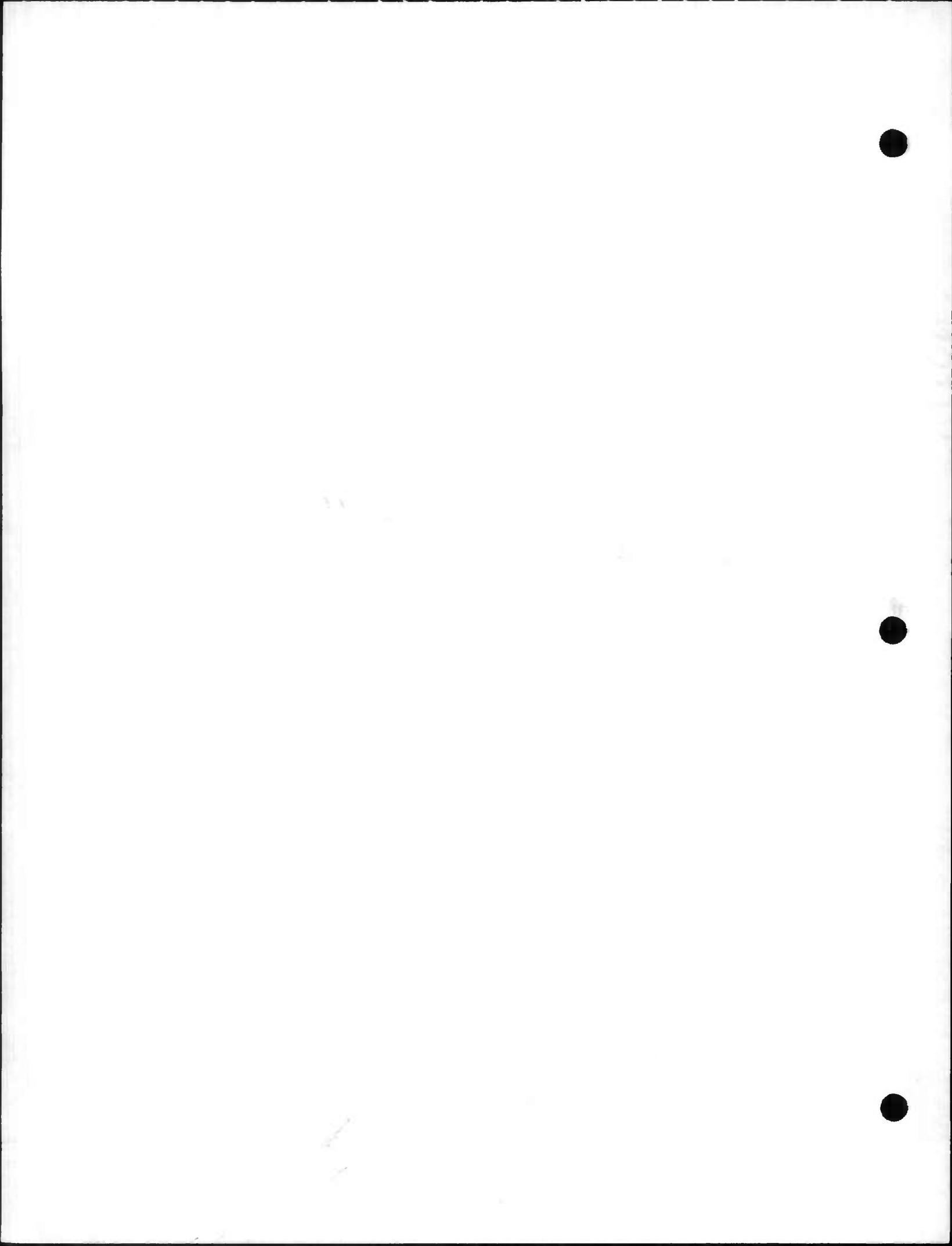
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. DECEASED'S NAME (First, Middle, Last) Mildred Eunice Black		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 95 19446		
4. SOCIAL SECURITY NUMBER 195 50 6979		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS 0		IF UNDER 24 HRS. DAYS 0		2. DATE OF DEATH MONTH DAY YEAR June 11, 1995		3. TIME OF DEATH 7:45 P M
9a. FACILITY NAME (If not institution, give street and number) Rockville Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Rockville						7. DATE OF BIRTH (Month, Day, Year) Dec. 21, 1909		
9c. COUNTY OF DEATH Montgomery		8. BIRTHPLACE (State or Foreign Country) Ontario, Canada								
RESIDENCE OF DECEASED										
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Chevy Chase						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 7103 Fulton Street				10f. ZIP CODE 20815				10g. CITIZEN OF WHAT COUNTRY? United States		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) John Franklin Adams				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah White						
19a. INFORMANT'S NAME (Type/Print) Susan Black Elwell				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7103 Fulton Street, Chevy Chase, MD 20815						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Montgomery Crematorium, Inc.				20c. LOCATION — City or Town, State Bethesda, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Bethesda-Chevy Chase, Inc. 7557 Wisconsin Avenue, Bethesda, MD 20814-3501						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Congestive Heart Failure										
a. DUE TO (OR AS A CONSEQUENCE OF): Pneumonia										
b. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Multi infarct. Dementia								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 29730				29d. DATE SIGNED (Month, Day, Year)  ► June 12, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James M. Anchors, M.D. 16220 Frederick Road #210 Gaithersburg, Maryland 20877										
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE 								



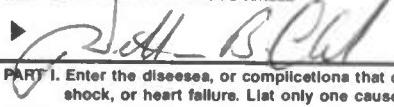
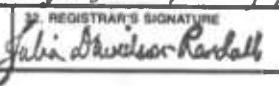
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

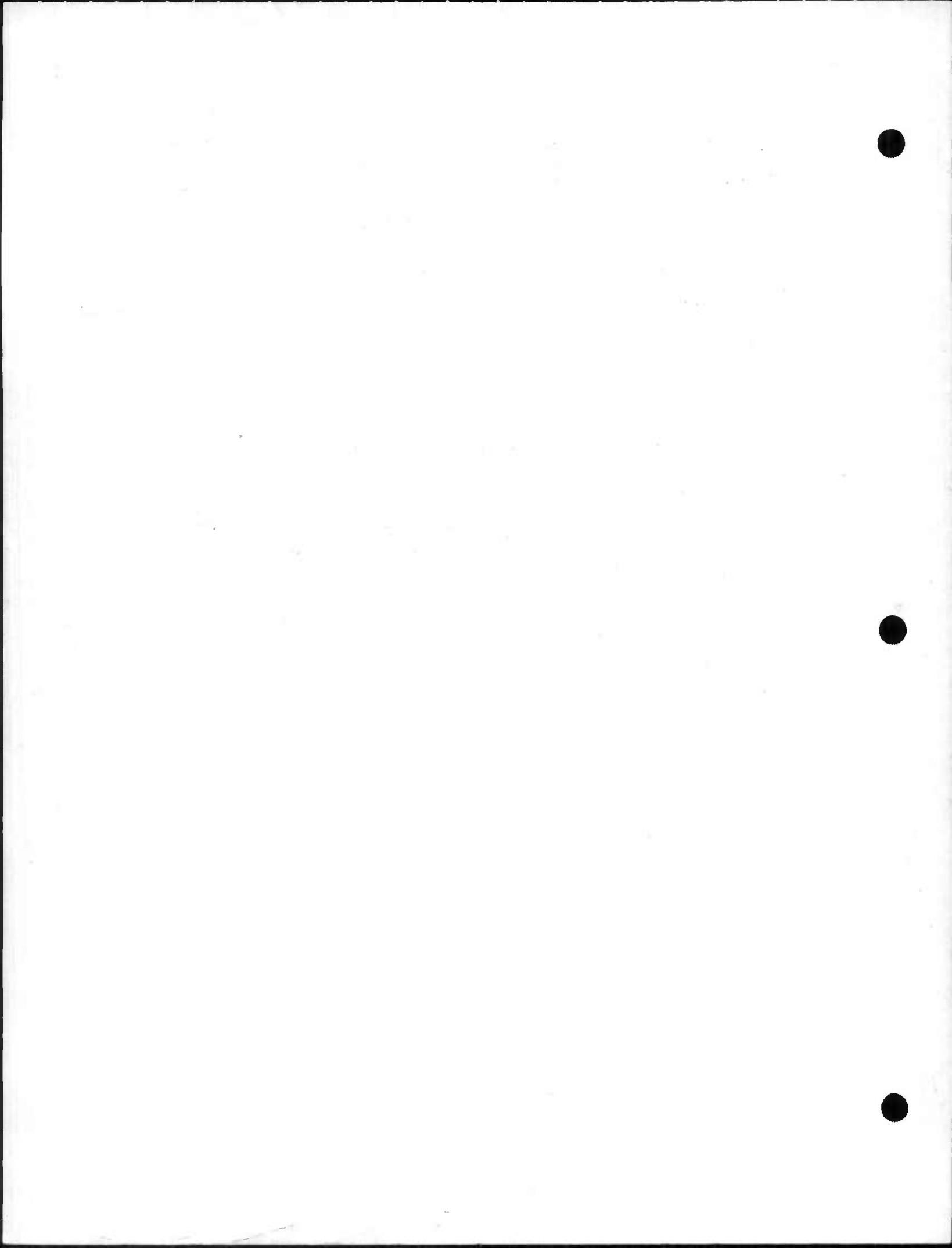
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR													95 19447		
1. DECEDENT'S NAME (First, Middle, Last) BRYAN Thomas Edwin BISNEY													2. DATE OF DEATH MONTH JUNE DAY 12 - YEAR 1995	3. TIME OF DEATH YEAR 11:55 pm	
4. SOCIAL SECURITY NUMBER 463-42-4178			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 29, 1908			8. BIRTHPLACE (State or Foreign Country) Canada			
9a. FACILITY NAME (If not institution, give street and number) Suburban Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Bethesda										9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT															
10a. STATE Maryland	10b. COUNTY Montgomery			10c. CITY, TOWN OR LOCATION Bethesda										10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 5803 Ryland Drive													10f. ZIP CODE 20817	10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Producer				16b. KIND OF BUSINESS/INDUSTRY Television							
17. FATHER'S NAME (First, Middle, Last) Frederick Bisney													18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Payne		
19a. INFORMANT'S NAME (Type/Print) John F. Bisney (Son)													19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory				DATE 6-14	20c. LOCATION — City or Town, State Beltsville, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 													22. NAME AND ADDRESS OF FACILITY Rapp Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →													Approximate Interval Between Onset and Death days		
a. <i>Aspiration Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):															
b. _____ DUE TO (OR AS A CONSEQUENCE OF):															
c. _____ DUE TO (OR AS A CONSEQUENCE OF):															
d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Carcinoma of Pancreas</i>													24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										24c. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													29d. DATE SIGNED (Month, Day, Year) ► 8/13/95		
29b. SIGNATURE AND TITLE OF CERTIFIER  19410 Al. Carlson Rd., Bethesda, MD 20814													29c. LICENSE NUMBER DLO516		
31. DATE FILED (Month, Day, Year) JUN 15 1995													32. REGISTRAR'S SIGNATURE 		



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19448

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH		
PAUL MILTON BOWER						JUNE 14, 1995	6:30 AM		
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
511-05-8845		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	79 YRS.	MONTHS	DAYS	HOURS	MIN.	JULY 19, 1915	KANSAS
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
5245 KALMIA DR.						DAYTON		HOWARD CO.	
10e. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
MD.		HOWARD		DAYTON				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
5245 KALMIA DR.						21036		U.S.A.	
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE	
1 Elementary/Secondary (0-12)		College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) OFFICE SUPPLIER			16b. KIND OF BUSINESS/INDUSTRY GINNS CO.	
17. FATHER'S NAME (First, Middle, Last) GEORGE BOWER						18. MOTHER'S NAME (First, Middle, Maiden Surname) BERTHA TAYLOR			
19e. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) JEFF R. PONTRLELLI SAME AS ITEM #10						
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WALKER CHAPEL CEMETERY			DATE 6/16	20c. LOCATION — City or Town, State ARLINGTON, VA.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i>			22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO. INC., SILVER SPRING, MD. 20910						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PARKINSON'S DISEASE DUE TO (OR AS A CONSEQUENCE OF):									
Approximate Interval Between Onset and Death 20 yrs.									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerotic cardiovascular Disease</i>									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Steven M. Zimmerman</i>		29c. LICENSE NUMBER VA 0101-019393		29d. DATE SIGNED (Month, Day, Year) ► 6/14/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN M. ZIMMERMAN 1400 S. JOYCE ST. ALEX VA 22202									
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE <i>Sabrina Randall</i>							

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$$= \partial_{\mu} + \frac{ie}{c} \vec{\epsilon}_{\mu} \vec{A}$$

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

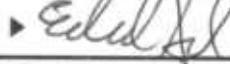
TO BE COMPLETED BY FUNERAL DIRECTOR

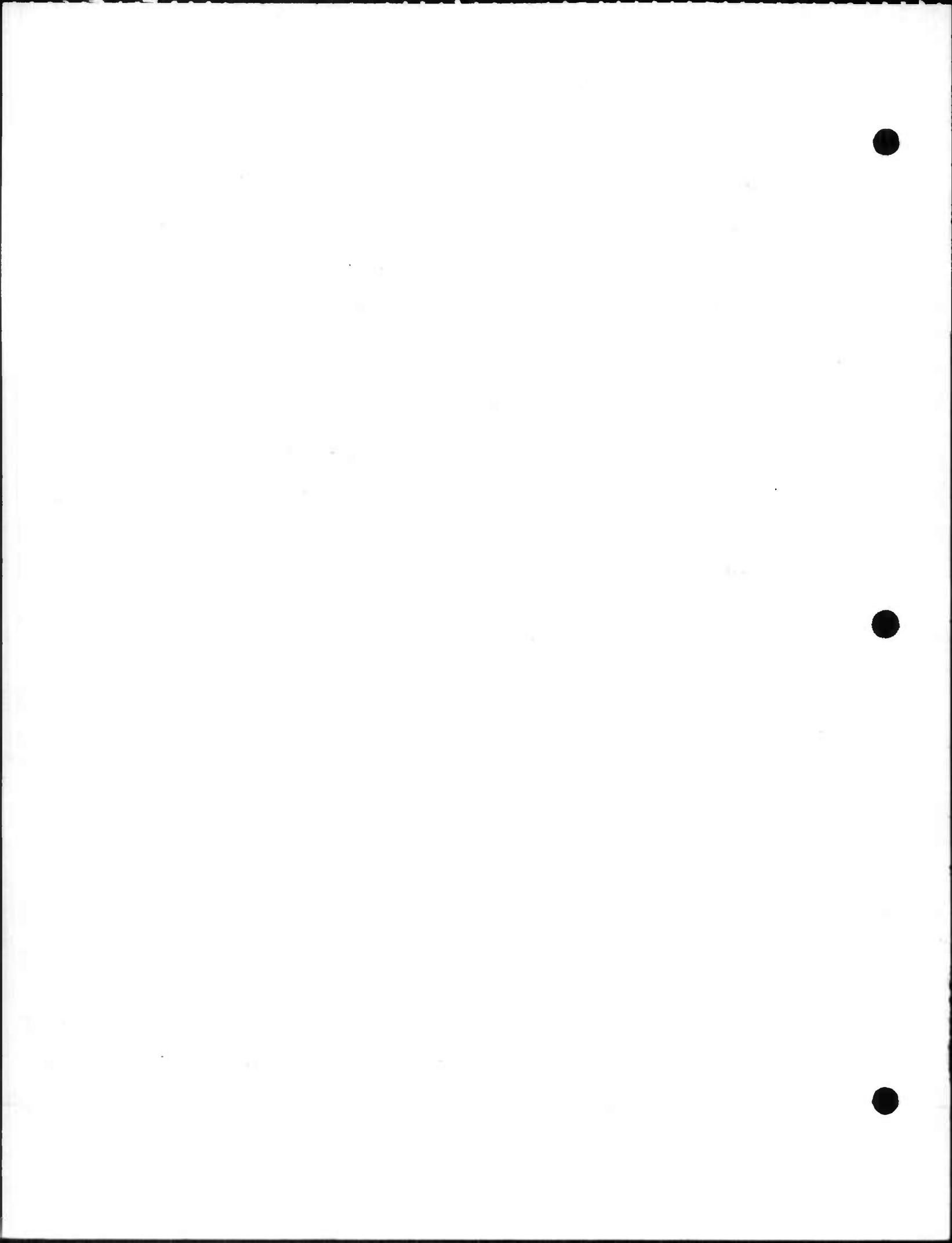
1 - STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19449

1. DECEDENT'S NAME (First, Middle, Last) Anna Battino				2. DATE OF DEATH MONTH JUN DAY 2 YEAR 1995	3. TIME OF DEATH 2:15 P.M.
4. SOCIAL SECURITY NUMBER 214-42-5375		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 96 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home of Greater Washington				7. DATE OF BIRTH (Month, Day, Year) NOV 15 1898	
				8. BIRTHPLACE (State or Foreign Country) Greece	
9b. CITY, TOWN OR LOCATION OF DEATH Rockville				9c. COUNTY OF DEATH Montgomery	
10a. STATE MD		10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Silver Spring	10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 8708 First Avenue				10f. ZIP CODE 20910	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Housewife	
17. FATHER'S NAME (First, Middle, Last) Schlomo Negrine				16. MOTHER'S NAME (First, Middle, Maiden Surname) Mazal Pallia	
19a. INFORMANT'S NAME (Type/Print) Victor Battino				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8708 First Avenue Silver Spring MD 20910	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) King David Memorial Gardens		DATE 6-6	20c. LOCATION — City or Town, State Falls Church VA
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852	
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA OF URINARY BLADDER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to Immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. c. d.					
Approximate Interval Between Onset and Death YEARS					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. MULTI-INfarct DEMENTIA					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER D. D. Patel, M.D.		29c. LICENSE NUMBER 518084		29d. DATE SIGNED (Month, Day, Year) JUNE 02, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. D. Patel, M.D. 6121 MONROSE RD, Rockville, MD 20852					
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE Jahn Shulman Rabbell			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

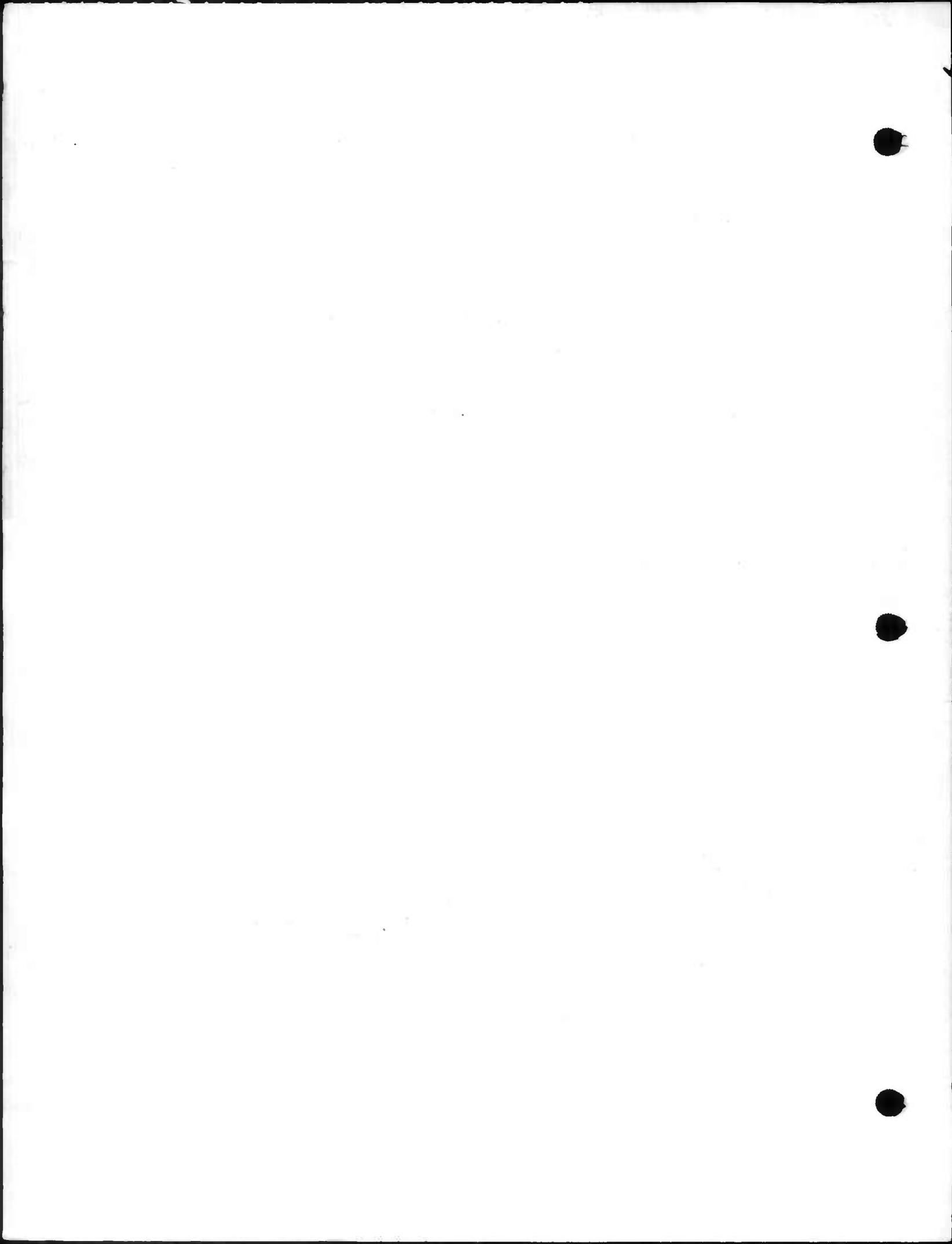
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR JUNE 04, 1995								3. TIME OF DEATH 11:29 AM	
1. DECEASED'S NAME (First, Middle, Last) PHYLLIS ANN CHRISTOPHER										7. DATE OF BIRTH (Month, Day, Year) 07/26/47	
4. SOCIAL SECURITY NUMBER 216-48-5070		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 47 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Florida					
9a. FACILITY NAME (If not institution, give street and number) 209 Heights Avenue										9b. CITY, TOWN OR LOCATION OF DEATH Hurlock	
9c. COUNTY OF DEATH Dorchester											
RESIDENCE OF DECEASED											
10e. STATE Maryland	10b. COUNTY Dorchester		10c. CITY, TOWN OR LOCATION Hurlock								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 209 Heights Avenue										10f. ZIP CODE 21643	10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES 12th				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Coordinator				16b. KIND OF BUSINESS/INDUSTRY Packing Company			
17. FATHER'S NAME (First, Middle, Last) John Edgar Boyer										18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Annie Harris Lempke	
19a. INFORMANT'S NAME (Type/Print) Robert E. Christopher, Sr.										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 215, Hurlock, MD 21643	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Eastern Shore Veterans6-6				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hurlock, Maryland				DATE	20c. LOCATION — City or Town, State Hurlock, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Michael F. Eskow										22. NAME AND ADDRESS OF FACILITY Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Superior Vena Caval Syndrome DUE TO (OR AS A CONSEQUENCE OF): Carcinoma of the lung.										Approximate Interval Between Onset and Death	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. c. d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Ambulance <input type="checkbox"/> Other (Specify) N/A									
27. MANNER OF DEATH ✓ Natural ✓ Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY AM N/A		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO N/A		28d. DESCRIBE HOW INJURY OCCURRED N/A			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) N/A	
29b. SIGNATURE AND TITLE OF CERTIFIER A.R. WILKE MD PA.										29c. LICENSE NUMBER 211284	29d. DATE SIGNED (Month, Day, Year) ► 6.8.95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 400 Maryland Ave		32. REGISTRAR'S SIGNATURE Jane Davidson-Parkell									
31. DATE FILED (Month, Day, Year) JUN 12 95											



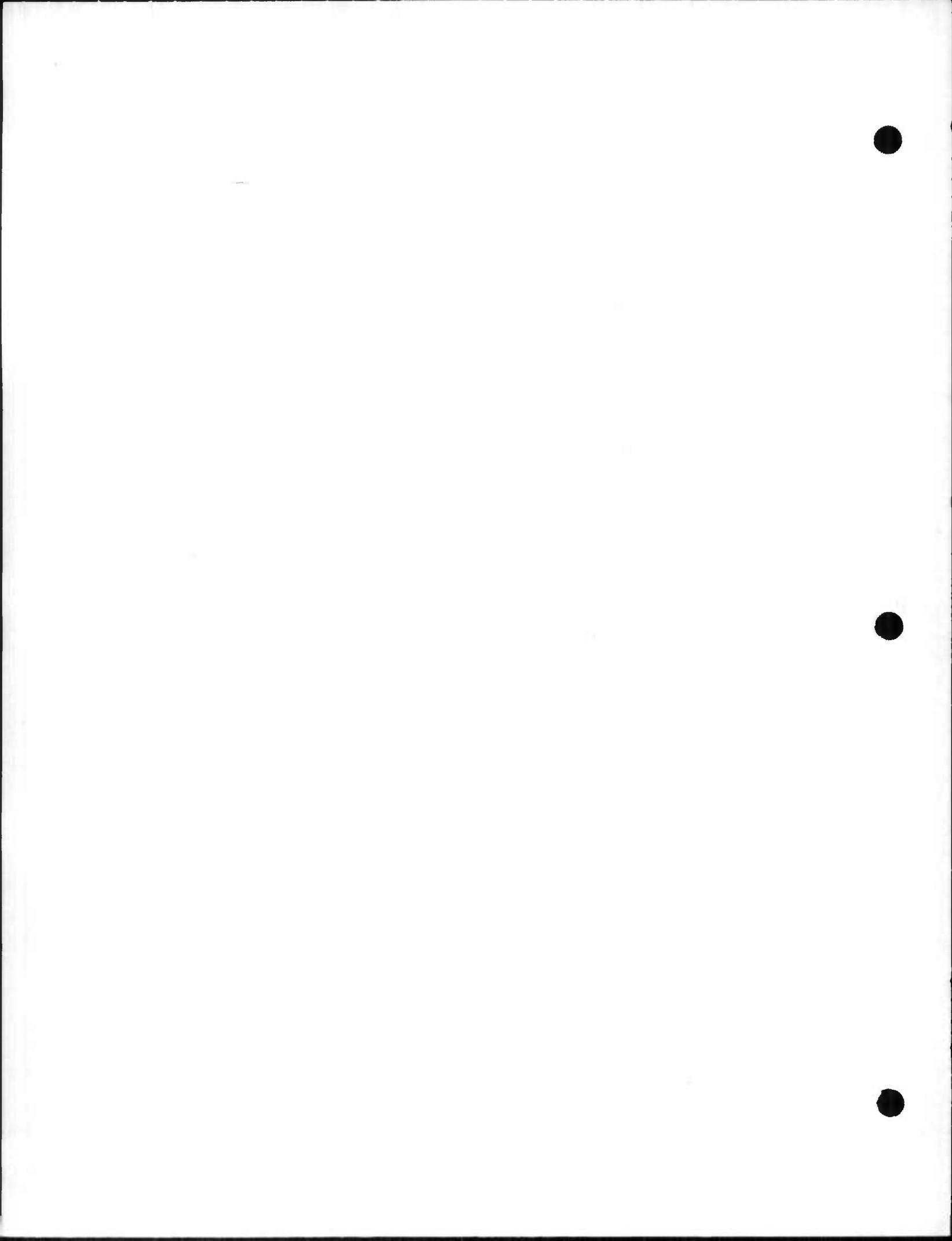
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)											
James Clifford Calloway											
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2. DATE OF DEATH MONTH		DAY	YEAR	3. TIME OF DEATH	
217-36-0794		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	90 YRS.	MONTHS	DAYS	May		26	1995	8:20 A M	
9a. FACILITY NAME (If not institution, give street and number)										9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
Memorial Hospital										Easton	Talbot
RESIDENCE OF DECEDENT											
10e. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?	
Maryland	Caroline	Denton								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER										10f. ZIP CODE	10g. CITIZEN OF WHAT COUNTRY?
303 Deep Shore Road										21629	U.S.A.
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Caucasian	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) 8		College (1-4 or 5+) Farmer				Farming					
17. FATHER'S NAME (First, Middle, Last)										18. MOTHER'S NAME (First, Middle, Maiden Surname)	
Walter Calloway										Bessie Sparks	
19a. INFORMANT'S NAME (Type/Print)										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
James C. Calloway, Jr.										816 Camp Road, Denton, Maryland 21629	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify): Greenmount Cemetery										DATE 5/30	20c. LOCATION — City or Town, State Hillsboro, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Randall P. Moore</i>										22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. PO Drawer B, Denton, Maryland 21629	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →										Approximate Interval Between Onset and Death hours	
a. <i>Pulmonary Edema</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. <i>Coronary Artery disease</i> DUE TO (OR AS A CONSEQUENCE OF): years											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Sepsis</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
6 <input type="checkbox"/> Could not be determined		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James Sides MD</i>										29c. LICENSE NUMBER D 31376	29d. DATE SIGNED (Month, Day, Year) ► 5/26/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
James Sides, M.D., PO Box 496, Denton, Maryland 21629											
31. DATE FILED (Month, Day, Year) MAY 30 95		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

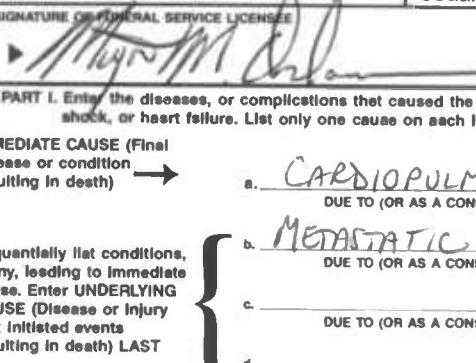
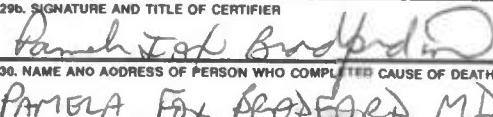
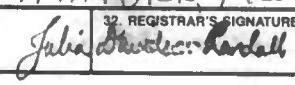
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

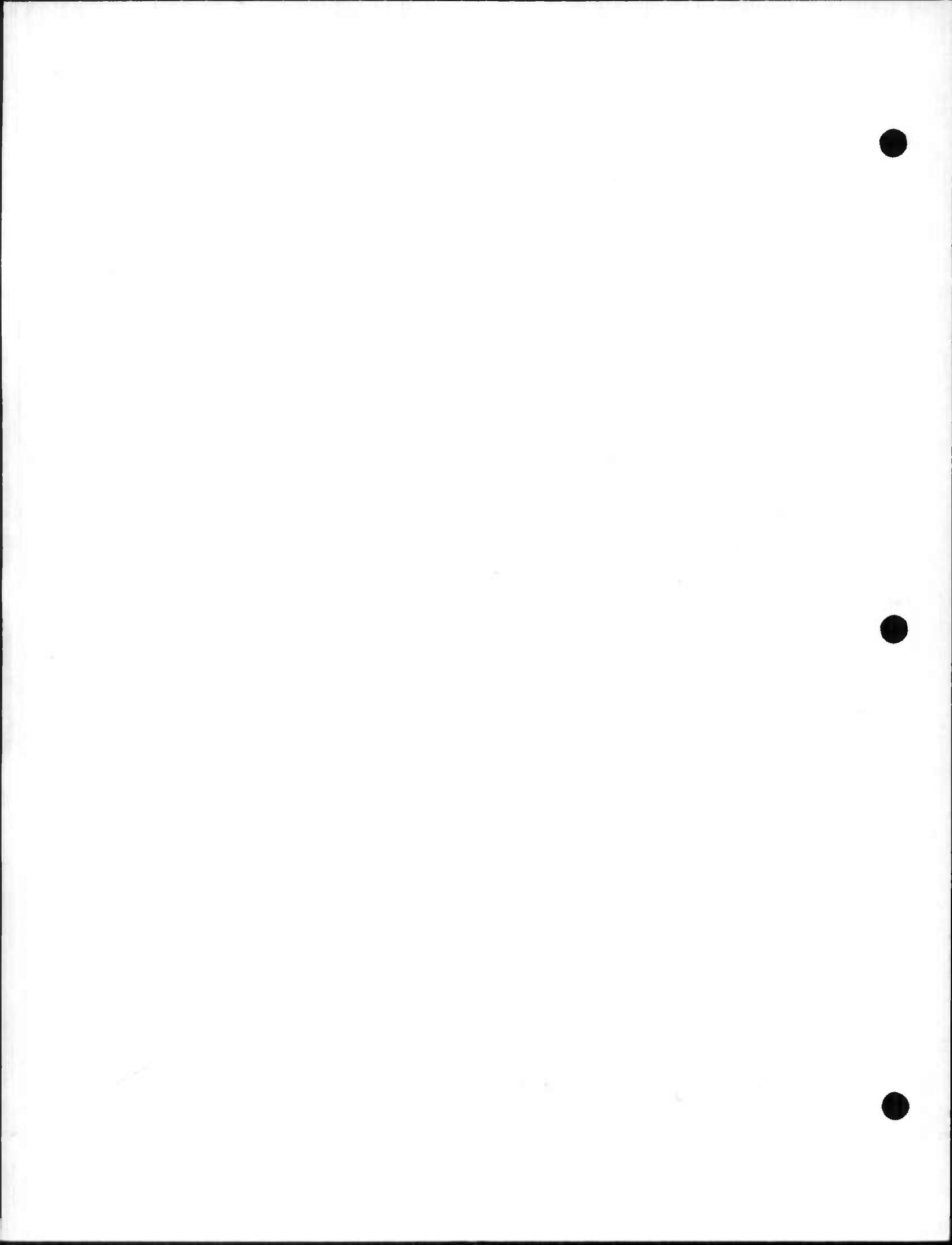
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH
John Cornwell COMBS								JUNE 19 1995		11:23 P.M.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)
214-12-3314		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	78 YRS.	MONTHS	DAYS	HOURS	MIN.	Mar. 30, 1917		Virginia
9a. FACILITY NAME (If not Institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH		
Washington County Hospital				Hagerstown				Washington		
RESIDENCE OF DECEDENT										
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?				
Maryland	Washington	Sharpsburg				<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?		
212 E. Chapline St.				21782				USA		
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced										
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (6-12) 12		College (14 or 5+) Stationery Engineer			Fairchild Aircraft					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)						
Eston Combs				Minnie Nevada Clark						
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Clarence L. Combs				432 Red Brick Rd. Millersville, MD. 21108						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place), Cedar Lawn Memorial Park June 22, 1995			DATE		20c. LOCATION — City or Town, State	
									Hagerstown, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Osborne Funeral Home P.O. Box 348 Williamsport, MD. 21795						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										
a. CARDIOPULMONARY ARREST DUE TO (OR AS A CONSEQUENCE OF):										
b. METASTATIC SQUAMOUS CELL CARCINOMA OF ORO- PHARYNX DUE TO (OR AS A CONSEQUENCE OF):										
c. DUE TO (OR AS A CONSEQUENCE OF):										
d. DUE TO (OR AS A CONSEQUENCE OF):										
Approximate Interval Between Onset and Death 15 MINUTES										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. HYPERTENSION, CONGESTIVE HEART FAILURE, PROBABLE ASPIRATION PNEUMONIA										
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D38892			29d. DATE SIGNED (Month, Day, Year) ► 6/19/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PAMELA FOX SPARFORD, MD		1799 HOWELL RD. HAGERSTOWN, MD 21740								
31. DATE FILED (Month, Day, Year) JUN 21 1995		32. REGISTRAR'S SIGNATURE Julie 								

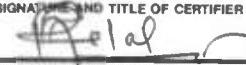


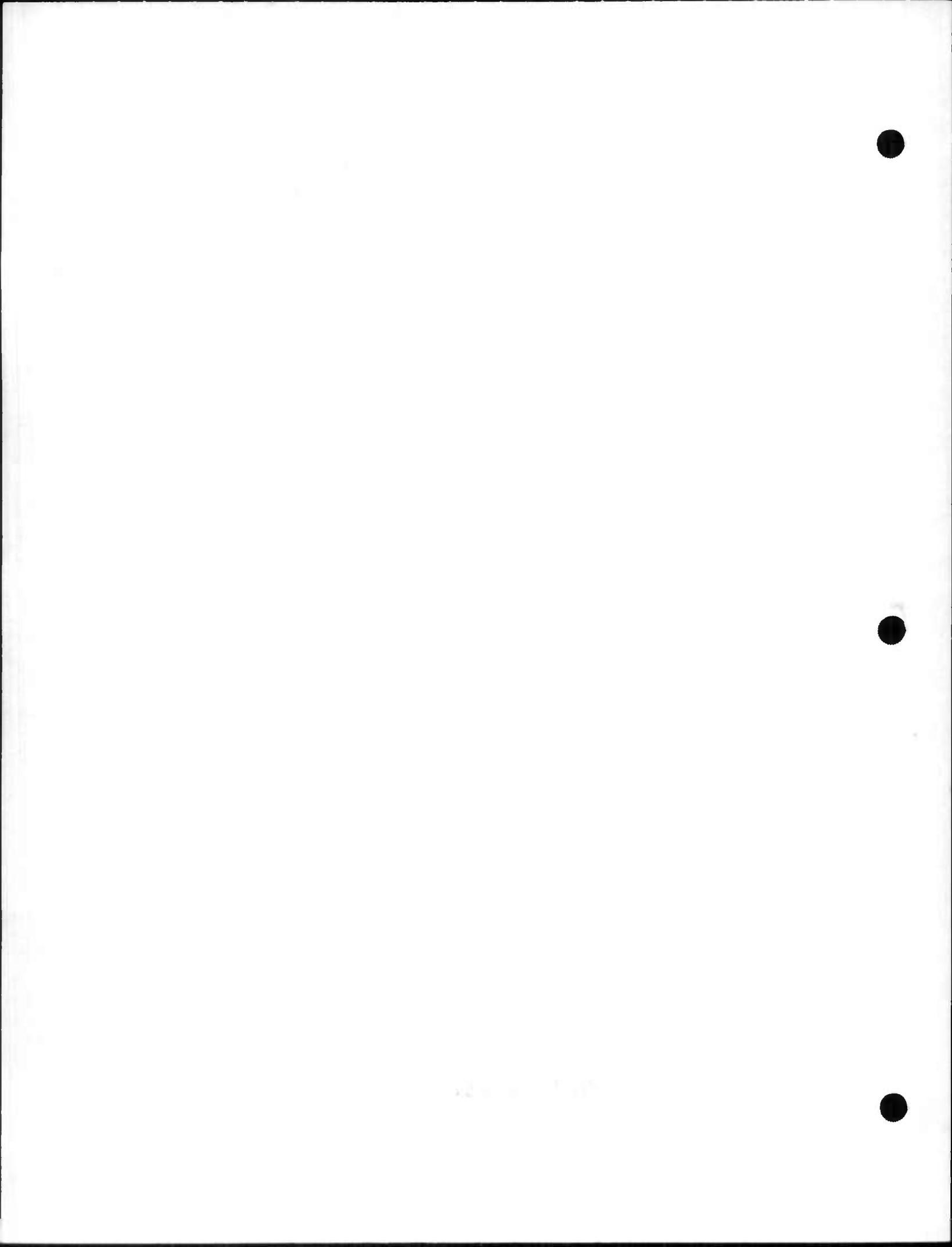
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 95 19453					
1. DECEDENT'S NAME (First, Middle, Last)		Joseph Wilmer			Carter			2. DATE OF DEATH MONTH JUN 5, 1995 DAY 0353 YEAR M			3. TIME OF DEATH						
4. SOCIAL SECURITY NUMBER 220-14-7744		5. SEX 1 ♂ 2 ♀ F		6. AGE (In yrs. last birthday) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month Day Year) June 19, 1922		8. BIRTHPLACE (State or Foreign Country) Md.					
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO													
10a. STATE Md.		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury, md.						10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 27454 Edgewood Circle						10f. ZIP CODE 21801				10g. CITIZEN OF WHAT COUNTRY? U.S.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY Domestic													
17. FATHER'S NAME (First, Middle, Last) Arthur Coates		18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Mae Mollison															
19a. INFORMANT'S NAME (Type/Print) Susie M. Coates		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 27454 Edgewood Circle - Salisbury, Md. 21801															
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springfield Cemetery		DATE 6/10		20c. LOCATION - City or Town, State Salisbury, Md. 21801											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Lewis N. Watson FUNERAL Home 1618 West Rd. Salisbury, Md. 21801															
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												Minutes					
a. CARDIAC ARREST DUE TO (OR AS A CONSEQUENCE OF):																	
b. CORONARY ARTERY DISEASE DUE TO (OR AS A CONSEQUENCE OF):												Years					
c. ACUTE PULMONARY OEDEMA DUE TO (OR AS A CONSEQUENCE OF):												-					
d.																	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE HYPERTENSION												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Investigation 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  MD		29c. LICENSE NUMBER D42522		29d. DATE SIGNED (Month, Day, Year) ► 6/15/95											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Prakash Dalal, md 614 - Eastern Shore Drive, Salisbury, md 21801		32. REGISTRAR'S SIGNATURE Julia Dawson Marshall															
31. DATE FILED (Month, Day, Year) JUN 07 1995												DHMH-16 Rev 1/89					



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

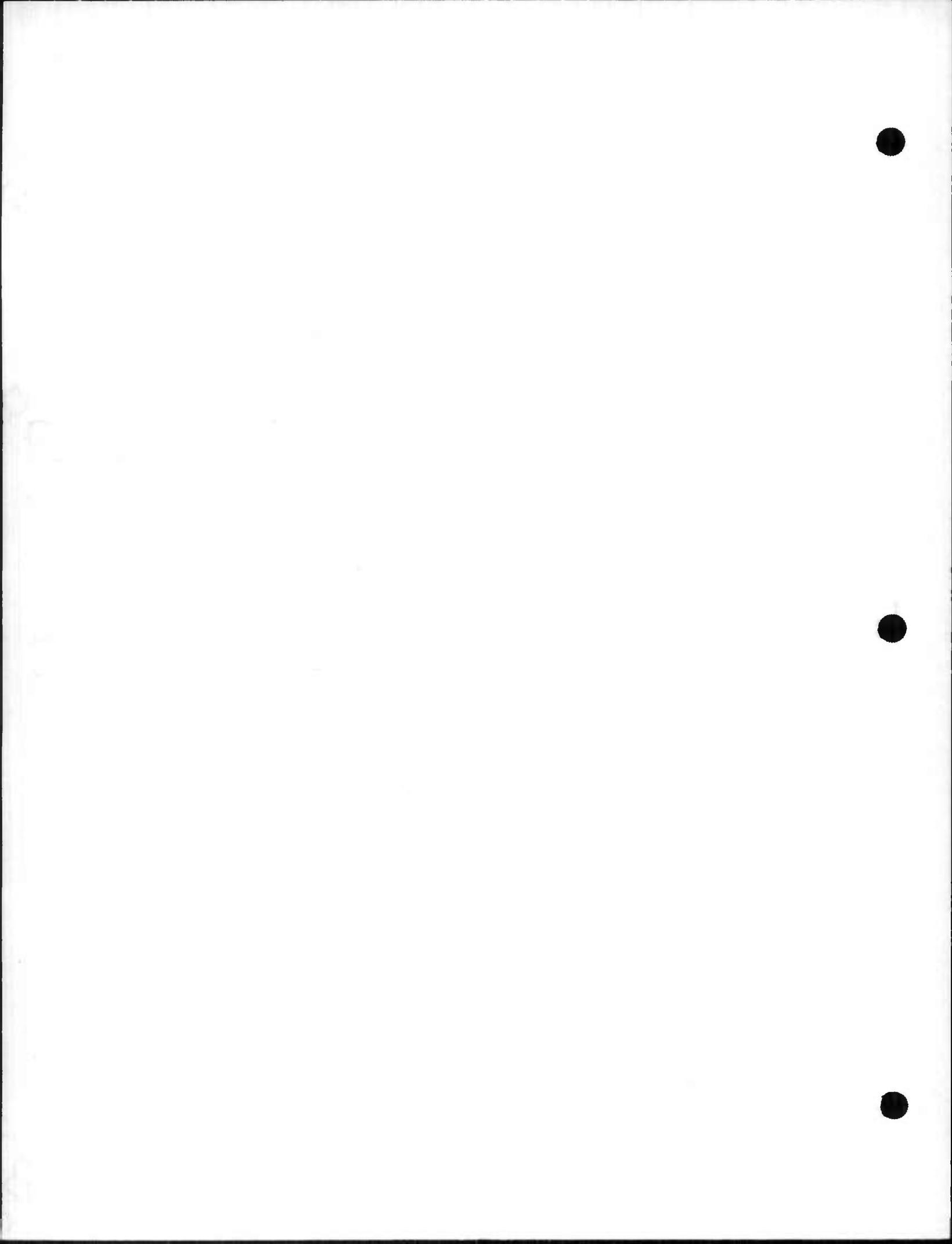
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) HELEN CADELLE COX							2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH		
4. SOCIAL SECURITY NUMBER 219-30-1957		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) November 4, 1919		8. BIRTHPLACE (State or Foreign Country) W. Virginia			
9a. FACILITY NAME (If not institution, give street and number) 1707 Tarleton Way							9b. CITY, TOWN OR LOCATION OF DEATH Crofton		9c. COUNTY OF DEATH Anne Arundel		
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Crofton				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 1707 Tarleton Way				10f. ZIP CODE 21114			10g. CITIZEN OF WHAT COUNTRY? United States				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Clerk			16b. KIND OF BUSINESS/INDUSTRY Nationwide Insurance					
17. FATHER'S NAME (First, Middle, Last) John Thomas Law				18. MOTHER'S NAME (First, Middle, Maiden Surname) Willie C. Webb							
19a. INFORMANT'S NAME (Type/Print) Millie J. Rawlings				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3305 Harness Creek Rd., Annapolis, Md. 21403							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Patuxant-Trinity Church Cem			DATE		20c. LOCATION — City or Town, State 6-14 Woodwardville, Md.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wayne J. Bushy				22. NAME AND ADDRESS OF FACILITY John M. Taylor Funeral Home, Inc. 147 Duke of Gloucester St., Annapolis, Md. 21401							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Progressive Respiratory Failure <small>DUE TO (OR AS A CONSEQUENCE OF):</small> COAD / EMPHYSEMA, with b. COR pulmonale & hypoxemia <small>DUE TO (OR AS A CONSEQUENCE OF):</small> c. Renal failure <small>DUE TO (OR AS A CONSEQUENCE OF):</small> d.										Approximate Interval Between Onset and Death Weeks	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Years	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Renal failure — resected.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER S.J. KRIMINS, M.D.				29c. LICENSE NUMBER 023142			29d. DATE SIGNED (Month, Day, Year) ► C/12/95				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) S.J. KRIMINS, M.D. 900 BESTBATE RD											
31. DATE FILED (Month Year) JUN 16 1995											



95 19455

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

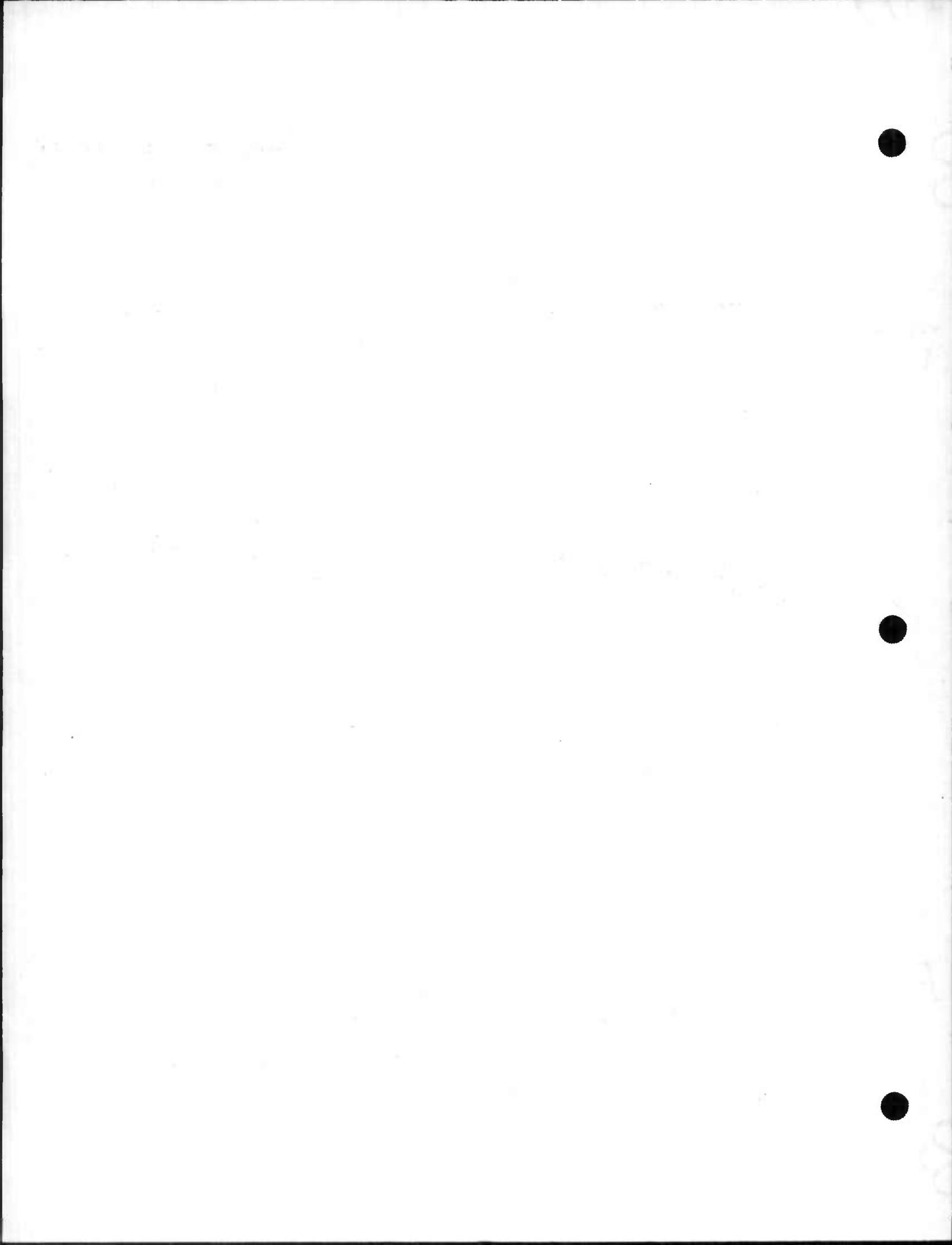
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 4 1995								3. TIME OF DEATH 17:51 PM	
1. DECEDENT'S NAME (First, Middle, Last) Beulah Josephine Conwell										7. DATE OF BIRTH (Month, Day, Year) 6/21/21	
4. SOCIAL SECURITY NUMBER 217-22-5587		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 73 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	
9c. COUNTY OF DEATH Washington											
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 663 Pennsylvania Avenue					10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? U.S.A		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No -- If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Black		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (14 or 5+) Minister			16b. KIND OF BUSINESS/INDUSTRY Church/ Religious						
17. FATHER'S NAME (First, Middle, Last) Walter Edward Campher					18. MOTHER'S NAME (First, Middle, Maiden Surname) Catherine Jones						
19a. INFORMANT'S NAME (Type/Print) McKeever E. Conwell					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4243 St. Vincents Dr. Balt., MD. 21215						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MD. National Mem. Pk			DATE 6/10/95		20c. LOCATION — City or Town, State Laurel, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas E. Watts					22. NAME AND ADDRESS OF FACILITY Watsons Funeral HM. 24 W. Bethel St. Hagerstown, MD. 21740						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (First disease or condition resulting in death) →										Few/Hour	
a. Cardiorespiratory Failure DUE TO (OR AS A CONSEQUENCE OF): Septicemia											
b. Pneumonia Bilateral DUE TO (OR AS A CONSEQUENCE OF): Cerebral Encephalopathy with Coma										1-2 Wks	
c. Septicemia DUE TO (OR AS A CONSEQUENCE OF): Pneumonia Bilateral										1-2 Wks	
d. Cerebral Encephalopathy with Coma DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D35947								29d. DATE SIGNED (Month, Day, Year) ► 6.6.95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) T.A. PASCHAL MD 376 MILL STREET HAGERSTOWN, MD 21740											
31. DATE FILED (Month, Day, Year) JUN 1995		32. REGISTRAR'S SIGNATURE Jabi Shuler-Carroll									



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

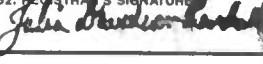
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

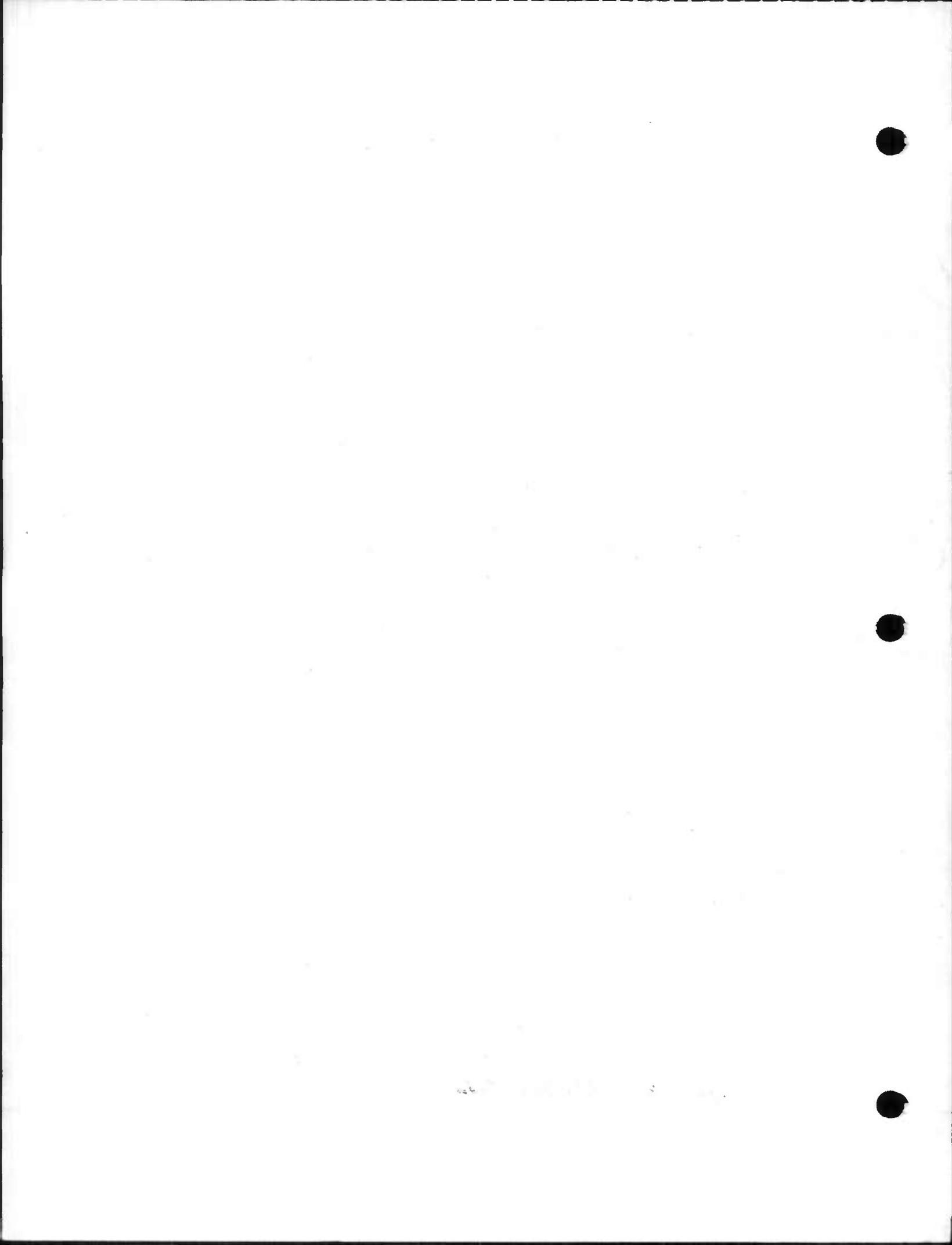
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

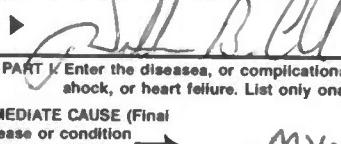
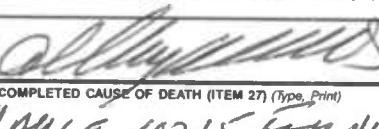
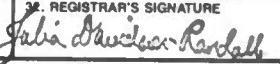
1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. 95 19456	
1. DECEDENT'S NAME (First, Middle, Last) FRANCIS Eugene COBLE, Sr.							2. DATE OF DEATH MONTH DAY YEAR MAY 29 1995		3. TIME OF DEATH 10:01 A M	
4. SOCIAL SECURITY NUMBER 216-14-6620		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 27, 1919		8. BIRTHPLACE (State or Foreign Country) Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number) University of Maryland Hospital							9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT										
10e. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Williamsport				10d. INSIDE CITY LIMITS? 1 NO				
10e. STREET AND NUMBER 14725 Clear Spring Rd.				10f. ZIP CODE 21795		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 Never Married 2 X Married 3 Widowed 4 Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 NO IF YES, GIVE WAR OR DATES 1936-1938			13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 NO			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Supervisor			16b. KIND OF BUSINESS/INDUSTRY Utility/Electric					
17. FATHER'S NAME (First, Middle, Last) John Dallas Coble, Sr.					16. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Elizabeth Brechbill					
19e. INFORMANT'S NAME (Type/Print) Mildred B. Cable					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14725 Clear Spring Rd. Williamsport, MD 21795					
20a. METOD OF DISPOSITION 1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GreenTawn Mem. Park			DATE 06/01/1995		20c. LOCATION — City or Town, State Williamsport, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Osborne Funeral Home 425 S. Conococheague St. Williamsport, MD 21795					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → CORONARY ARTERY DISEASE										
a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										
b. DUE TO (OR AS A CONSEQUENCE OF):										
c. DUE TO (OR AS A CONSEQUENCE OF):										
d. DUE TO (OR AS A CONSEQUENCE OF):										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? 1 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN									1 NO	1 NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 NO		28. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 ER/Outpatient 3 DOA							OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)	
27. MANNER OF DEATH 1 X Natural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide 7 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 NO		28d. DESCRIBE HOW INJURY OCCURED		
		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29e. CERTIFIER (Check only one) 2 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29. SIGNATURE AND TITLE OF CERTIFIER A. PARK MD								
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. PARK MD		22. S GREENE ST. BALTIMORE, MD 21201		29c. LICENSE NUMBER 5731		29d. DATE SIGNED (Month, Day, Year) ► 5/29/95				
31. DATE FILED (Month, Day, Year) JUN - 1 1995		32. REGISTRAR'S SIGNATURE 								



95 19457

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG NO.

1. DECEDENT'S NAME (First, Middle, Last) MARGARET ELIZABETH COSTINETT				2. DATE OF DEATH MONTH DAY YEAR JUNE 14, 1995	3. TIME OF DEATH P.M. 7:17	
4. SOCIAL SECURITY NUMBER 577-12-8449		5. SEX <input checked="" type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0		
8a. FACILITY NAME (If not institution, give street and number) 4521 East-West Highway #1107				7. DATE OF BIRTH (Month, Day, Year) March 22, 1907	8. BIRTHPLACE (State or Foreign Country) Washington, D.C.	
9a. CITY, TOWN OR LOCATION OF DEATH Bethesda				9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT						
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Bethesda			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 4521 East-West Highway #1107			10f. ZIP CODE 20814		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (6-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last) Edward Blade				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillian Slagle		
19a. INFORMANT'S NAME (Type/Print) Margaret Ann Stephens				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3352 Chiswick Ct #1F, Silver Spring, MD 20906		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Chesapeake Crematory		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Chesapeake Crematory		DATE 6-15	20c. LOCATION — City or Town, State Beltsville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00827				22. NAME AND ADDRESS OF FACILITY Happ Funeral Services, P.A. 933 Gist Ave, Silver Spring, MD 20910		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>MYOCARDIAL INFARCTION</u> DUE TO (OR AS A CONSEQUENCE OF): <u>ACUTE</u>						
b. <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> DUE TO (OR AS A CONSEQUENCE OF): <u>INDEX</u>						
c. <u></u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u>						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER 007099		29d. DATE SIGNED (Month, Day, Year) June 15, 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C. MCALE 10215 Fernwood Rd Bethesda MD 20817						
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE 				

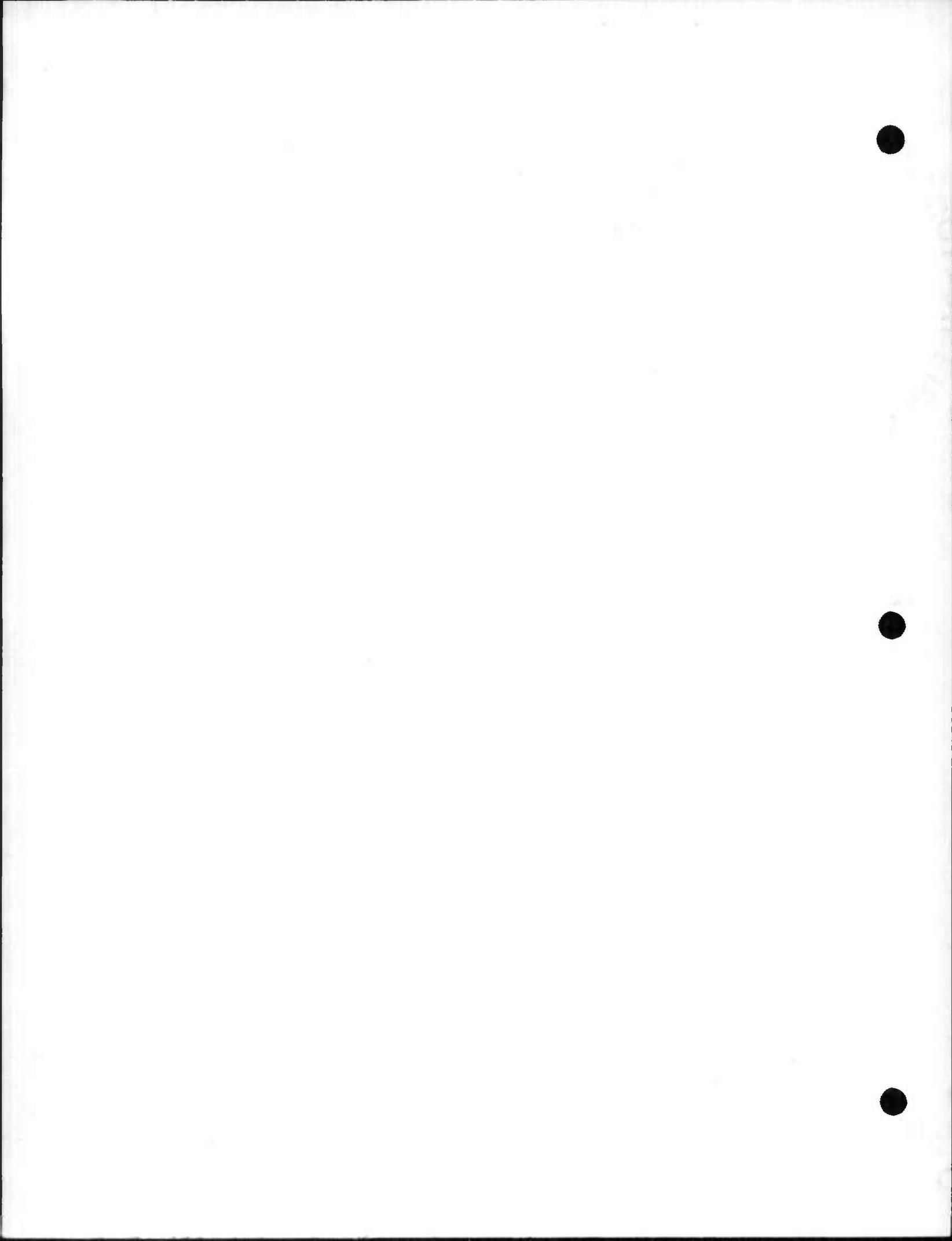
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

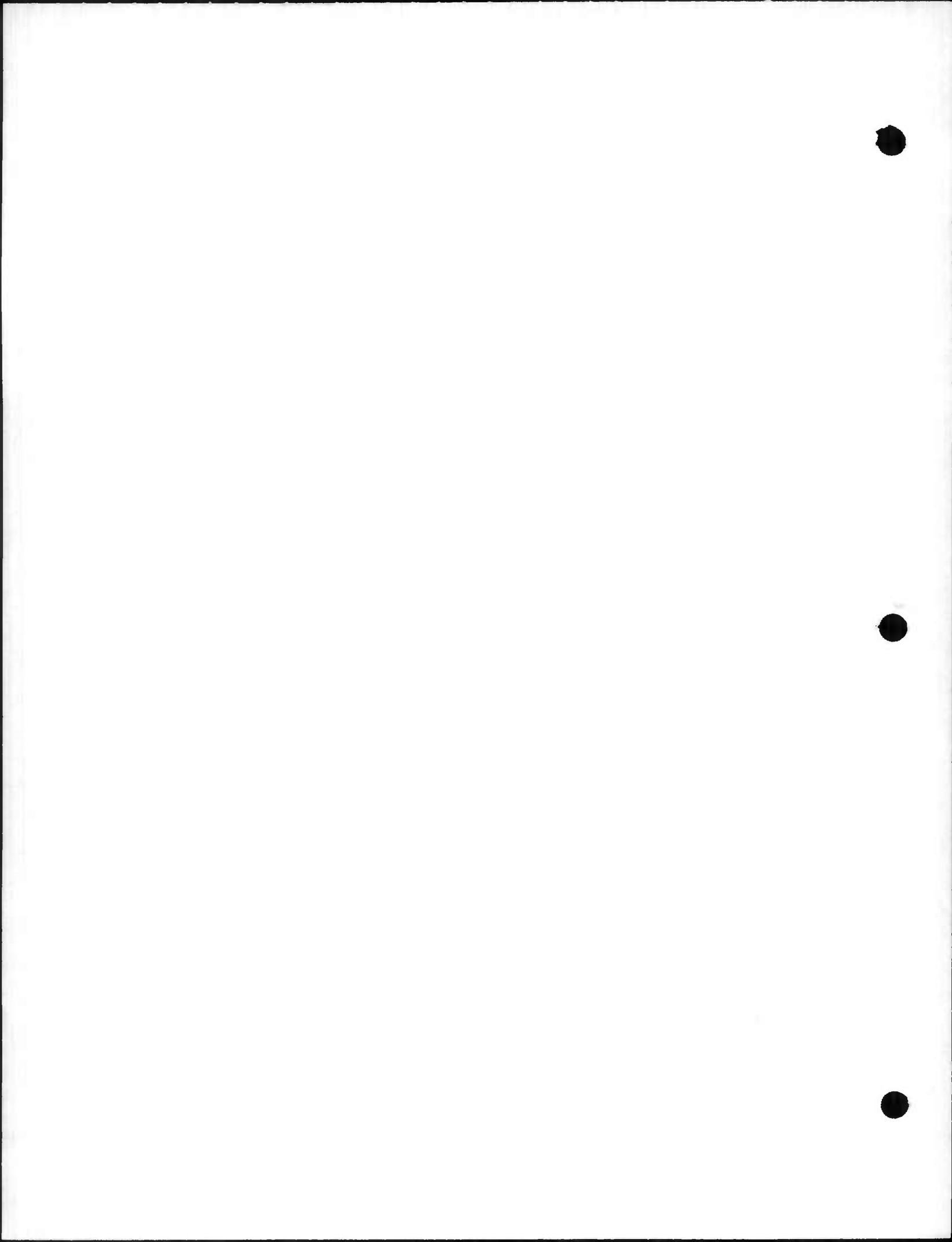
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR										3. TIME OF DEATH 3:50 P M			
1. DECEDENT'S NAME (First, Middle, Last) Paul Alfred Clukey												7. DATE OF BIRTH (Month, Day, Year) Nov. 7, 1914	8. BIRTHPLACE (State or Foreign Country) New York		
4. SOCIAL SECURITY NUMBER 080-03-4123		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 80 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.									
9a. FACILITY NAME (If not institution, give street and number) Kensington Gardens Nursing Center												9b. CITY, TOWN OR LOCATION OF DEATH Kensington	9c. COUNTY OF DEATH Montgomery		
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring				10f. ZIP CODE 20906							
10e. STREET AND NUMBER 12214 Charles Road												10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: White				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) President Dry Wall				16b. KIND OF BUSINESS/INDUSTRY Own Company									
17. FATHER'S NAME (First, Middle, Last) Edward Paul Clukey		18. MOTHER'S NAME (First, Middle, Maiden Surname) Beatrice Flemings													
19e. INFORMANT'S NAME (Type/Print) Wayne C. Clukey		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12214 Charles Road Silver Spring, Maryland 20906													
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory				DATE 6/10/95		20c. LOCATION — City or Town, State Alexandria, Virginia							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert E. Ramsey</i>		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral Infarct</i>												Month			
a. <u>Cerebral Infarct</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Years			
b. <u>Cerebrovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): { c. <u>DUE TO (OR AS A CONSEQUENCE OF):</u> d. <u>DUE TO (OR AS A CONSEQUENCE OF):</u>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes Mellitus; Gastrointestinal Hemorrhage with Shock, perforated ulcer with Peritonitis, Hypertension</u> DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				OTHER: 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Martin - Shargel M.D.</i>		29c. LICENSE NUMBER D 08944				29d. DATE SIGNED (Month, Day, Year) ► June 9, 1995									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Martin C. Shargel, M.D. 3720 Farragut Avenue Kensington, MD 20895															
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE <i>Julie Shargel-Randall</i>													



DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

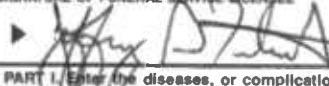
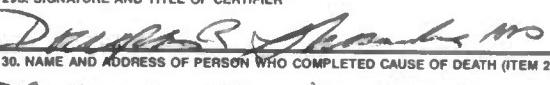
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 6 hours after death. Page 6 may be retained by the hospital or attending physician.

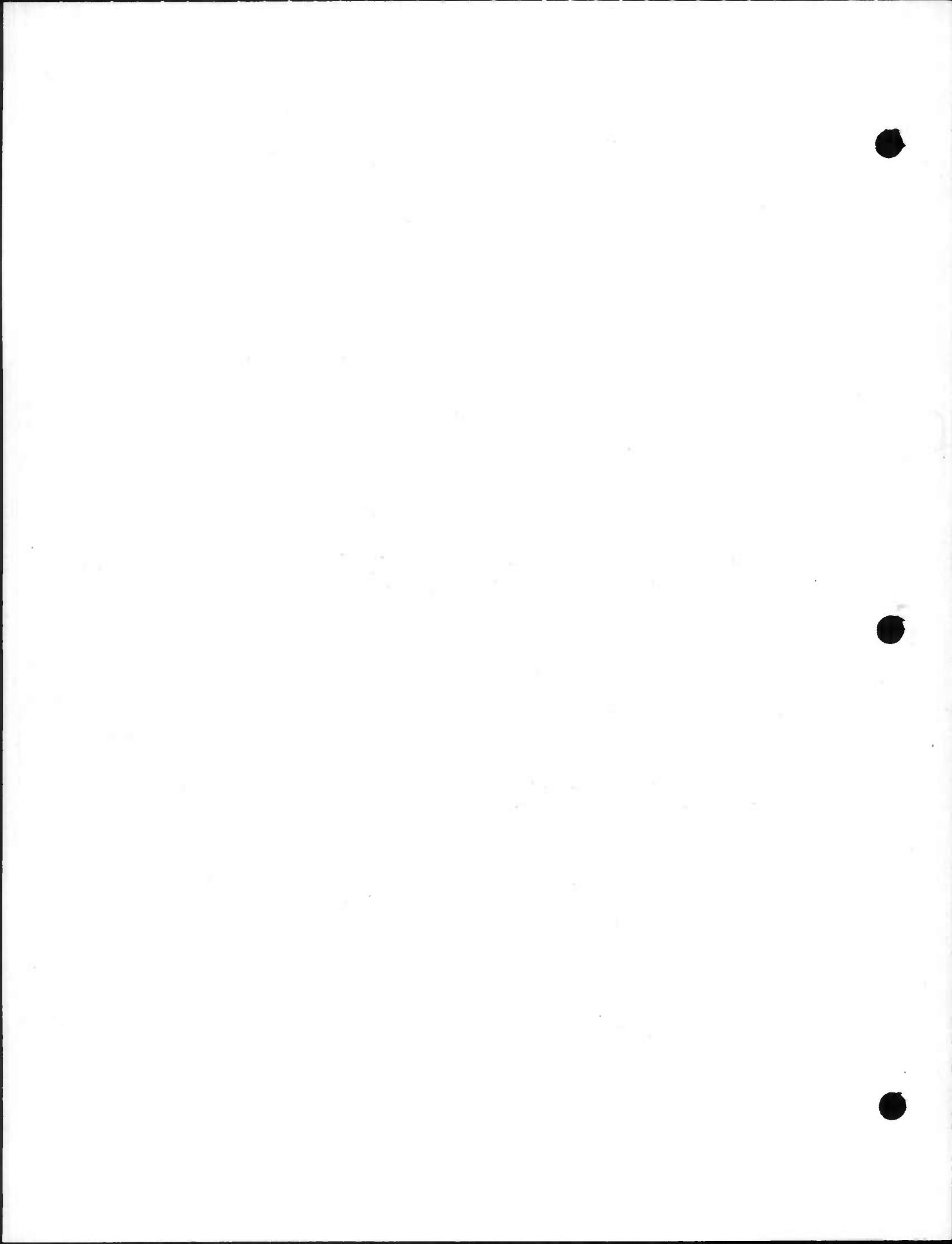
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR								3. TIME OF DEATH	
		June 8 1995								1146 PM	
1. DECEASED'S NAME (First, Middle, Last)		Ernest Conklin			7. DATE OF BIRTH (Month, Day, Year)			8. BIRTHPLACE (State or Foreign Country)			
Glenn					June 2, 1929			Kansas			
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	8. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			9. FACILITY NAME (If not institution, give street and number)			
512 22 3557		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	66 YRS.				Shady Grove Adventist Hospital			9b. CITY, TOWN OR LOCATION OF DEATH	
										Rockville	
										9c. COUNTY OF DEATH	
										Montgomery	
RESIDENCE OF DECEASED											
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
Maryland	Montgomery	Derwood									
10e. STREET AND NUMBER		10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
16617 Killdeer Drive		20855				United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
		Korea									
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) —		College (14 or 5+) 5+ Physicist				Radiation					
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)									
William T. Conklin		Jenny Lind									
19e. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)									
Barbara J. Conklin		16617 Killdeer Drive, Derwood, Maryland 20855									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State			
		Parklawn June 13, 1995/Memorial Park						Rockville, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► 		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
b. Due to (or as a consequence of): Asystole											
Approximate Interval Between Onset and Death 5 years											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
{ b. Probable myocardial infarction 5 years c. Chronic Heart Disease 5 years											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Congestive Heart Failure		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
Atrial Fibrillation											
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH Natural Accident Suicide Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29e. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D27301				29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Douglas R. Summers MD 615 W. Montgomery Ave Rockville MD 20850											
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE Julia Dawson-Robell									



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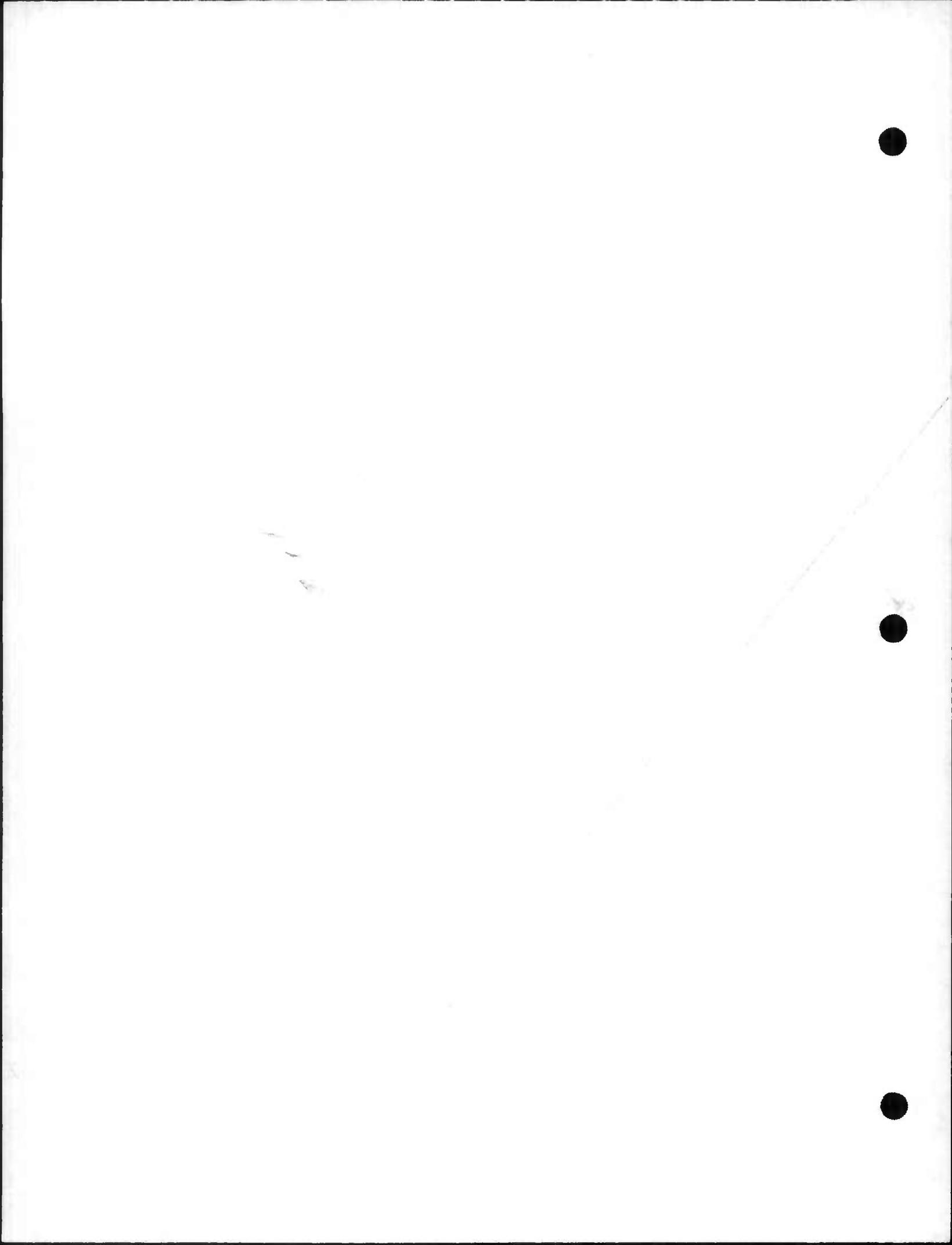
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19460

10. RESIDENCE OF DECEASED		11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Chinese						
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 11519 February Circle, #201		10f. ZIP CODE 20904		10g. CITIZEN OF WHAT COUNTRY? United States		
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY										
Elementary/Secondary (0-12) 12		College (1-4 or 5+) 0		Laundry Worker								Housekeeping Industry		
17. FATHER'S NAME (First, Middle, Last) Unknown						18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown								
19a. INFORMANT'S NAME (Type/Print) Shu O. Chan						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11519 February Circle, #201 Silver Spring, MD 20904								
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery						DATE 6/14	20c. LOCATION — City or Town, State Silver Spring, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert J. Finken</i>						22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home, Inc. 11800 New Hampshire Ave., Silver Spring, MD								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death <i>2 days</i>		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i>														
e. DUE TO (OR AS A CONSEQUENCE OF): <i>Cong cancer</i>														
b. DUE TO (OR AS A CONSEQUENCE OF):														
c. DUE TO (OR AS A CONSEQUENCE OF):														
d. DUE TO (OR AS A CONSEQUENCE OF):														
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>														
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael L. Bonitz, MD</i>										29c. LICENSE NUMBER P08089	29d. DATE SIGNED (Month, Day, Year) ► JUN 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael L. Bonitz, MD 11800 New Hampshire Ave., Silver Spring, MD 20904</i>														
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>Jeanine R. Randal</i>												



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TO BE COMPLETED BY FUNERAL DIRECTOR

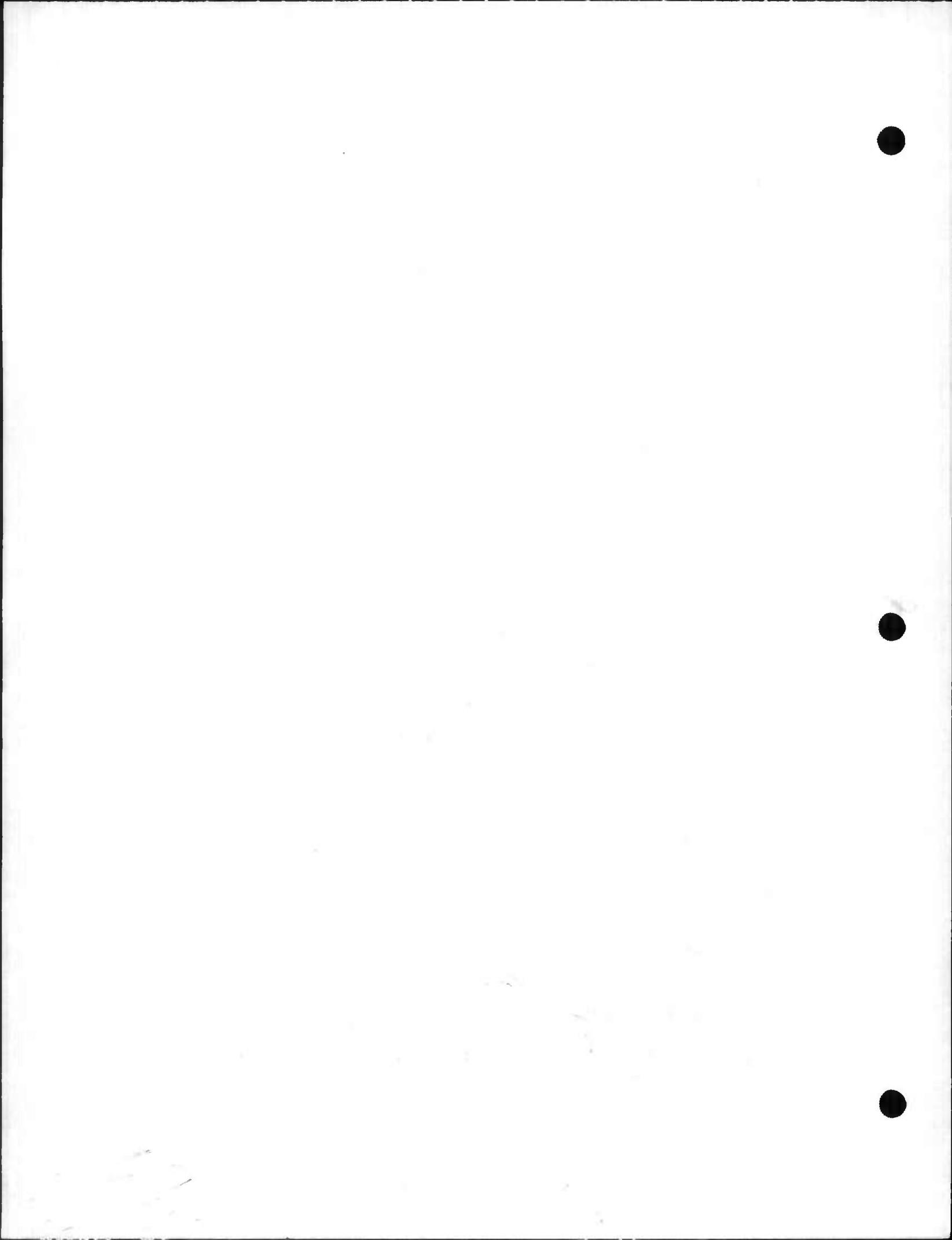
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19461

1. DECEDENT'S NAME (First, Middle, Last) Zaitoon Choudhry						2. DATE OF DEATH MONTH DAY YEAR June 9, 1995	3. TIME OF DEATH 1:55 PM
4. SOCIAL SECURITY NUMBER N/A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 69 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) Sept 4, 1925	8. BIRTHPLACE (State or Foreign Country) Pakistan	
9a. FACILITY NAME (If not institution, give street and number) 2 Bentley Ct			9b. CITY, TOWN OR LOCATION OF DEATH Rockville			9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEDENT							
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2 Bentley Ct			10f. ZIP CODE 20853			10g. CITIZEN OF WHAT COUNTRY? Pakistan	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES None		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: Indian			14. RACE — American Indian, Black, White, etc. Specify: Indian
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) 5+ Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Mohammad Asghar				18. MOTHER'S NAME (First, Middle, Maiden Surname) Asghari Begum			
19a. INFORMANT'S NAME (Type/Print) Shalla Khan			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2 Bentley Ct, Rockville, MD 20853				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) George Washington Cemetery			DATE Jul 11	20c. LOCATION — City or Town, State Adelphi, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Alan J. Donnell			22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Ave, Silver Spring, MD				
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a.	<i>Chronic Renal Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Diabetes</i>						
b.	<i>Arteriosclerosis</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Ischaemic heart disease</i>						
c.							
d.							
Approximate Interval Between Onset and Death							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nonsuicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Philip Schwartz MD		29c. LICENSE NUMBER 024398			29d. DATE SIGNED (Month, Day, Year) ► 6-9-95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Philip Schwartz MD		31. DATE FILED (Month, Day, Year) JUN 14 1995					
		REGISTRAR'S SIGNATURE John B. Stedman, R.R.C.					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

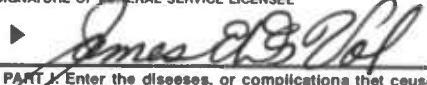
TO BE COMPLETED BY FUNERAL DIRECTOR

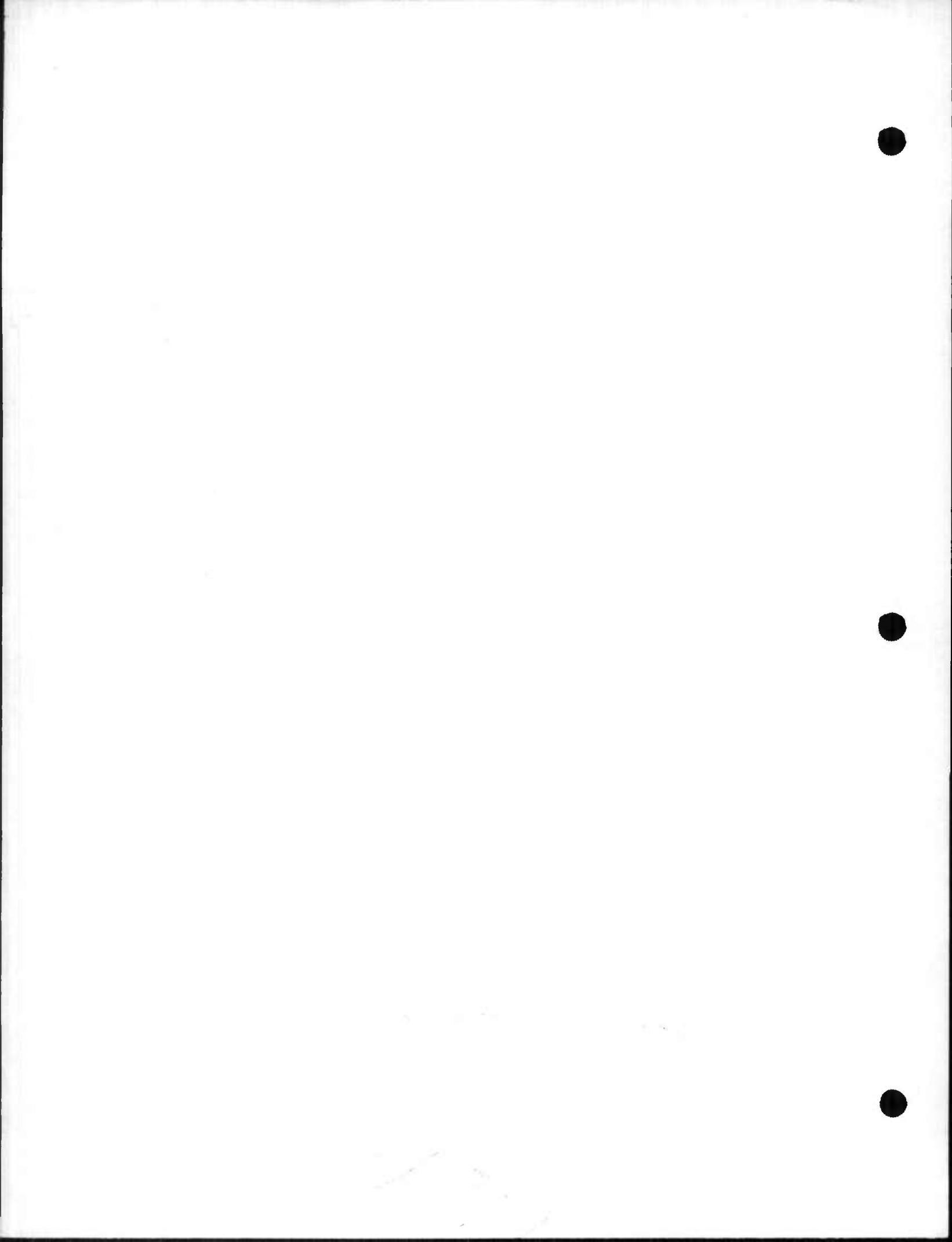
FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19462

1. DECEDENT'S NAME (First, Middle, Last)						2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH 11:10 P.M.
Grace Brennan Carberry						June 11, 1995	
4. SOCIAL SECURITY NUMBER 104-32-6329		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
8a. FACILITY NAME (If not institution, give street and number) Manor Care						7. DATE OF BIRTH (Month, Day, Year) Apr. 19, 1905	
9b. CITY, TOWN OR LOCATION OF DEATH Bethesda						8. BIRTHPLACE (State or Foreign Country) New York	
9c. COUNTY OF DEATH Montgomery							
RESIDENCE OF DECEDED							
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Bethesda				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5217 Cammack Drive			10f. ZIP CODE 20816			10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		
15. DECEDED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 4 school teacher			16b. KIND OF BUSINESS/INDUSTRY New York City Schools		
17. FATHER'S NAME (First, Middle, Last) Thomas Brennan				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emma Flynn			
19a. INFORMANT'S NAME (Type/Print) Michael G. Carberry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5217 Cammack Dr., Bethesda, Md. 20816			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Long Island National Cem. Jun 15, 95			DATE	20c. LOCATION — City or Town, State Farmingdale, N.Y.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home 2222 Wisconsin Ave., N.W., Wash., DC 20007			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. acute myocardial infarct Approximate Interval Between Onset and Death immediate							
b. arteriosclerotic heart disease 2 years							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER Do4179					
		29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James J. Foster, M.D., 5530 Wisconsin Ave., #925, Chevy Chase, Md. 20815		31. REGISTRAR'S SIGNATURE John Shuster Randall					
31. DATE FILED (Month, Day, Year) JUN 15 1995							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

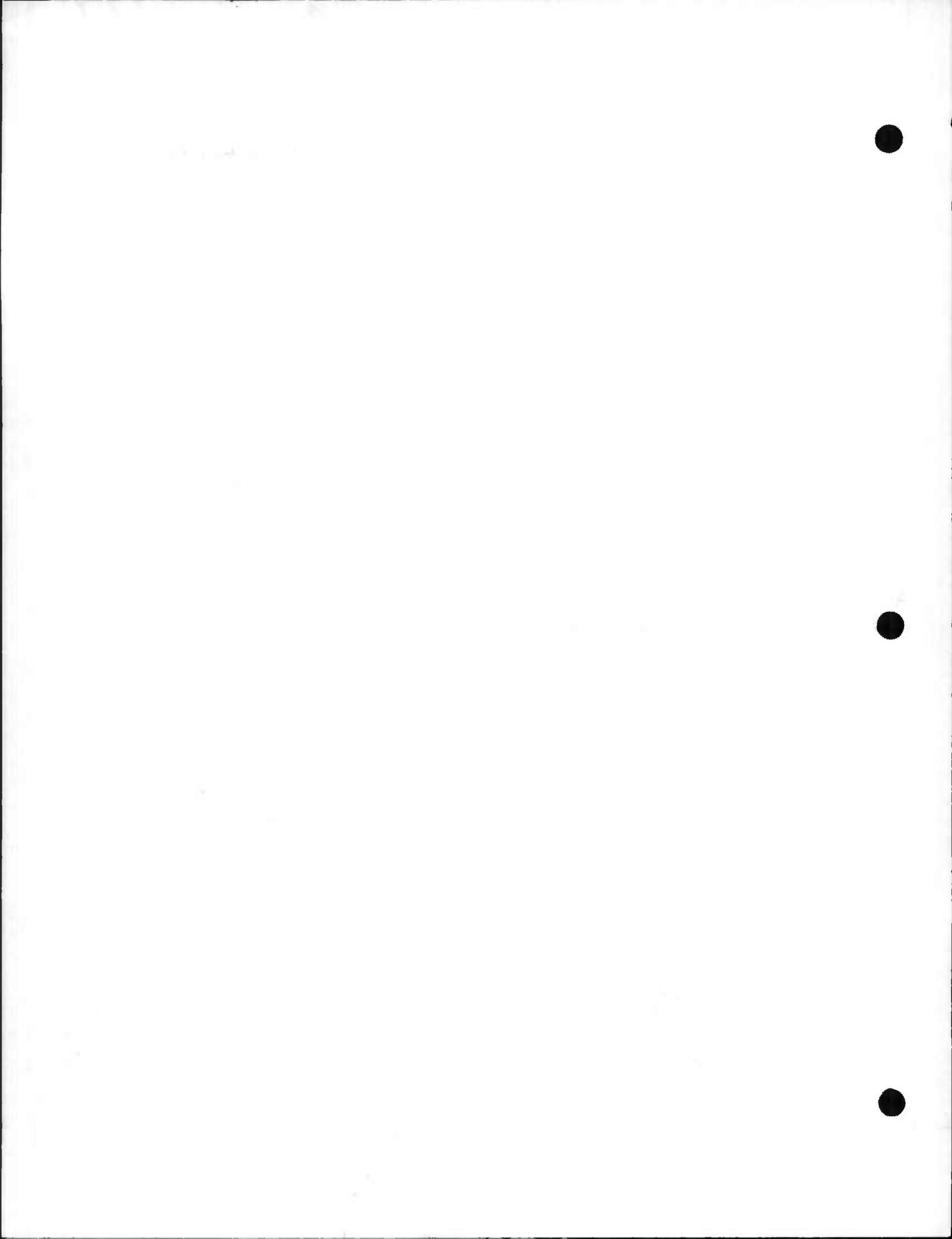
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)			Cohen									2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 140 P M	
Alexander												June 13, 1995			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTNPLACE (State or Foreign Country)			
577-09-9927		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		78 YRS.		MONTHS DAYS		HOURS MIN.		NOV. 9, 1916		MINNESOTA			
9e. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH									9c. COUNTY OF DEATH			
LAUREL REGIONAL HOSPITAL			LAUREL									PRINCE GEORGES			
RESIDENCE OF DECEDENT															
10e. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
MARYLAND		MONTGOMERY		SILVER SPRING											
10e. STREET AND NUMBER			10f. ZIP CODE									10g. CITIZEN OF WHAT COUNTRY?			
1121 UNIVERSITY BLVD. W. #903			20902									UNITED STATES			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II									13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE		
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced															
15. DECEDENT'S EDUCATION (Specify only highest grade completed)			16e. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired)									16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12)			College (1-4 or 5+)									OWNER AUTO LEASING			
2															
17. FATHER'S NAME (First, Middle, Last)			16. MOTHER'S NAME (First, Middle, Maiden Surname)												
MORRIS COHEN			ANNIE GORDON												
19e. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)												
MARY COHEN (WIFE)			1121 UNIVERSITY BLVD. W. 903 SILVER SPRING, MD 20902												
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)									DATE		20c. LOCATION — City or Town, State	
												KING DAVID 6/15		FALLS CHURCH, VIRGINIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Thomas</i>			22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertension arteriosclerosis coronary artery disease</i>															
DUE TO (OR AS A CONSEQUENCE OF):															
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST															
{ b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Nomicide			28e. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)												
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ricardo Rodriguez MD</i>			29c. LICENSE NUMBER D21230									29d. DATE SIGNED (Month, Day, Year) June 13, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Ricardo Rodriguez MD, 5709 Rayburn Ct., Gaithersburg, MD 20878</i>															
31. DATE FILED (Month, Day, Year) JUN 16 1995			32. REGISTRAR'S SIGNATURE <i>Juliann Alexander Redball</i>									DHMH-16 Rev 1/89			



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

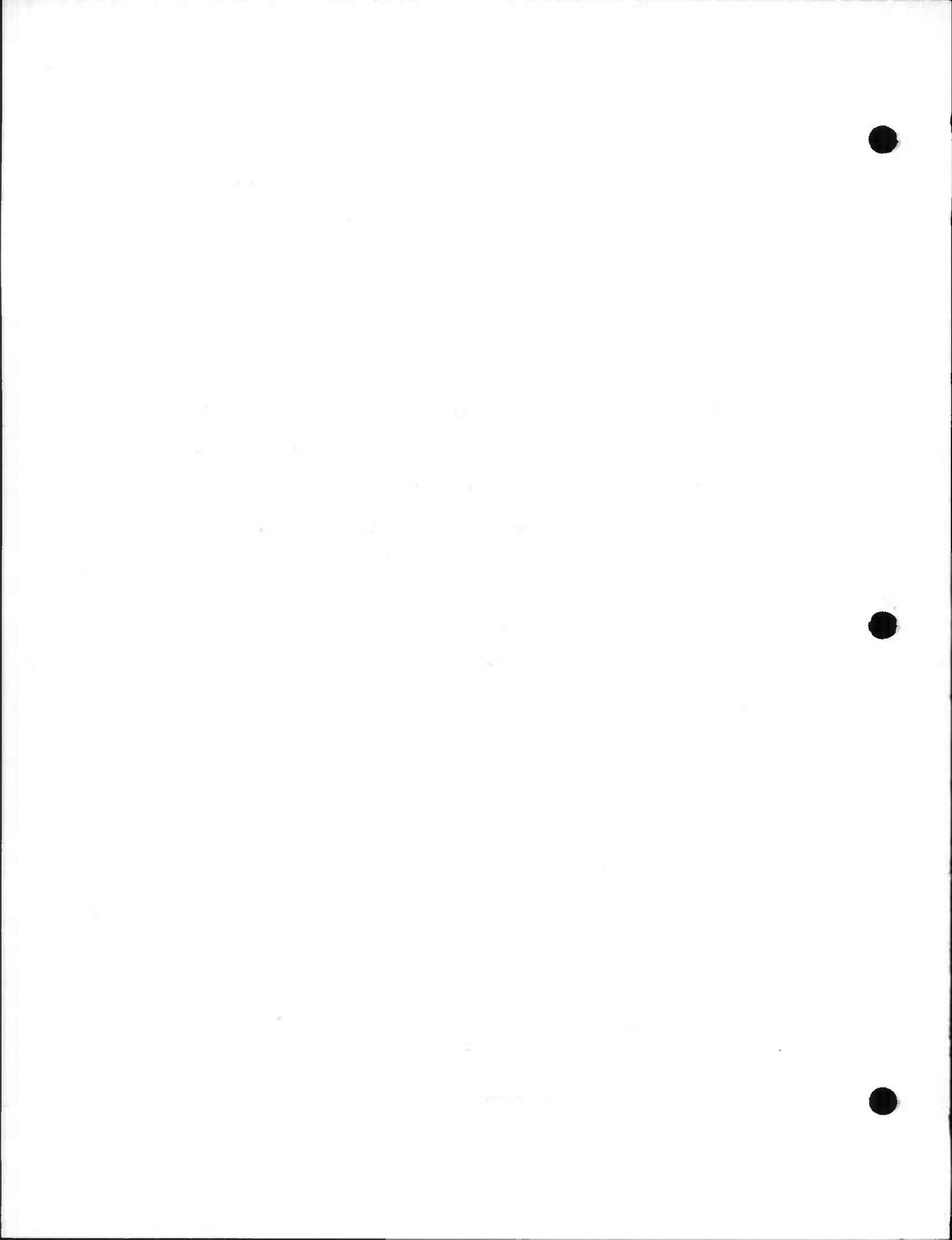
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Viola Wilhelmina Dorrell								6-11-95	11:10 a.m.
4. SOCIAL SECURITY NUMBER 213-34-4048		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 88 yrs.	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1-22-07		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie				9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Maryland		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 1136 Little Magothy View				10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Home				
17. FATHER'S NAME (First, Middle, Last) William T. Kesting				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilhelmina Jung					
19a. INFORMANT'S NAME (Type/Print) Evelyn Merson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as # 10					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery 6-14-95				DATE	20c. LOCATION — City or Town, State Baltimore, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park MD 21146					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
<p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>s. <i>Congestive Heart Failure</i></p> <p>b. <i>Cardiomyopathy</i></p> <p>c. <i>Stroke</i></p> <p>d. <i></i></p>									
<p>Approximate Interval Between Onset and Death</p> <p>10 days</p> <p>2 years</p> <p>2 years</p>									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Viola W. Dorrell, M.D.</i>				29c. LICENSE NUMBER D21684				29d. DATE SIGNED (Month, Day, Year) ► 6-14-95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C.V.-CYRIAC-M.D. 1600 CRAIN Hwy #wg GLEN BURNIE, MD 21061									
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE <i>Julie D. Wilkes-Randall</i>							



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. FOR STATE REGISTRAR										95 19465	
1. DECEDENT'S NAME (First, Middle, Last) Roy Corderman DURBIN										2. DATE OF DEATH MONTH DAY YEAR June 12, 1995	3. TIME OF DEATH HOUR MIN. 1140 A
4. SOCIAL SECURITY NUMBER 220-09-7697		5. SEX 1 M 2 F	6. AGE (In yrs. last birthday) 76 YRS.	IF UNDER 1 YEAR MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	7. DATE OF BIRTH (Month, Day, Year) June 14, 1918	8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) 18018 Hollyhock Road				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown			9c. COUNTY OF DEATH Washington				
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown								10d. INSIDE CITY LIMITS? 1 YES 2 NO	
10e. STREET AND NUMBER 18018 Hollyhock Road				10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 Never Married 2 Married 3 Widowed 4 Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 YES 2 NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 YES 2 NO Specify: white			14. RACE — American Indian, Black, White, etc. Specify: white			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) plumbing helper			16b. KIND OF BUSINESS/INDUSTRY						
17. FATHER'S NAME (First, Middle, Last) Elmer E. Durbin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cora S. Corderman							
19a. INFORMANT'S NAME (Type/Print) Helen M. Durbin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 18018 Hollyhock Road, Hagerstown, Maryland 21740							
20a. METHOD OF DISPOSITION 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Salem Church Cemetery 6-15-95				DATE	20c. LOCATION — City or Town, State Hagerstown, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Scott Minnick				22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death years	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. Lung cancer.											
DUE TO (OR AS A CONSEQUENCE OF): b. Due to (or as a consequence of): Lung cancer.											
c. Due to (or as a consequence of):											
d. Due to (or as a consequence of):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO		26. PLACE OF DEATH (Check only one) 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify)									
27. MANNER OF DEATH 1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 YES 2 NO	28c. INJURY AT WORK? M 1 YES 2 NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29c. SIGNATURE AND TITLE OF CERTIFIER M.D.		29c. LICENSE NUMBER D26806				29d. DATE SIGNED (Month, Day, Year) 6/13/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Allard Durbin 18018 Hollyhock Road Hagerstown MD 21740		31. DATE FILED (Month, Day, Year) JUN 1 31995		32. REGISTRAR'S SIGNATURE Jahn Corderman							

Ward 2000 - 10 -

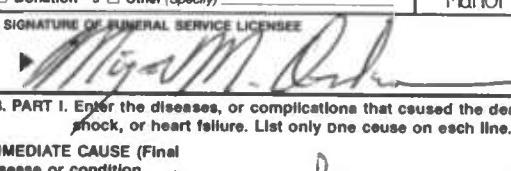
DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 08 95										3. TIME OF DEATH M	
1. DECEDENT'S NAME (First, Middle, Last) Harry William DAVIS													
4. SOCIAL SECURITY NUMBER 214-28-5733		5. SEX 1 X M 2 □ F	6. AGE (In yrs. last birthday) 63 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Aug. 18, 1931		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital												9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown	9c. COUNTY OF DEATH Washington
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Fairplay		10d. INSIDE CITY LIMITS? 1 □ YES 2 X NO		10g. CITIZEN OF WHAT COUNTRY? USA					
10e. STREET AND NUMBER 9237 Jordan Rd.						10f. ZIP CODE 21733		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 □ Never Married 2 X Married 3 □ Widowed 4 □ Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 X YES 2 □ NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 □ YES 2 X ND Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Fireman		16b. KIND OF BUSINESS/INDUSTRY Cushwa Brick Yard									
17. FATHER'S NAME (First, Middle, Last) Roy L. Davis						18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Blanche Jones							
19a. INFORMANT'S NAME (Type/Print) Ora Lorraine Turner Davis						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9237 Jordan Rd. Fairplay, MD. 21733							
20a. METHOD OF DISPOSITION 1 X Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Manor Cemetery		DATE June 10, 1995		20c. LOCATION — City or Town, State Tilghmanton, MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 						22. NAME AND ADDRESS OF FACILITY Osborne Funeral Home P.O.Box 348 Williamsport, MD. 21795							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death 9 months	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. lung cancer.													
DUE TO (DR AS A CONSEQUENCE OF):													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST													
b. _____ DUE TO (DR AS A CONSEQUENCE OF):													
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Obstructive pneumonia.													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES X NO □ UNCERTAIN □													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 □ YES 2 X ND		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 X Inpatient 2 □ ER/Outpatient 3 □ DDA OTHER: 4 □ Nursing Home 5 □ Residence 6 □ Other (Specify)											
27. MANNER OF DEATH 1 X Natural 5 □ Pending Investigation 2 □ Accident 3 □ Suicide 8 □ Could not be determined 4 □ Homicide													
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 □ YES 2 □ ND		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29e. CERTIFIER 1 X CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 □ MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER Hind Hamdan, MD						29c. LICENSE NUMBER D46473		29d. DATE SIGNED (Month, Day, Year) 6/9/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Hind Hamdan, MD. 363 S.Cleveland Ave., Suite 201; Hagerstown MD 21740													
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE 											

July 19

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)	MARY ISABELLE DEHART								2. DATE OF DEATH MONTH 6 DAY 4 YEAR 95		3. TIME OF DEATH 1:09P M				
4. SOCIAL SECURITY NUMBER 188-09-5024		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. least birthday) 78 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12/14/1916		8. BIRTHPLACE (State or Foreign Country) Quincy TWPPA.			
9a. FACILITY NAME (If not institution, give street and number) WASHINGTON COUNTY HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH HAGERSTOWN								9c. COUNTY OF DEATH WASHINGTON			
10a. STATE MD		10b. COUNTY WASHINGTON		10c. CITY, TOWN OR LOCATION HAGERSTOWN								10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 55 EAST WASHINGTON ST								10f. ZIP CODE 21740				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) MAINTENANCE				16b. KIND OF BUSINESS/INDUSTRY CRANE MG.									
17. FATHER'S NAME (First, Middle, Last) WILLIAM A. GOSSERT				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA MAE MONN											
19a. INFORMANT'S NAME (Type/Print) BEVERLY A. BARNHART				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 242 EAST MAIN ST WAYNESBORO PA 17268											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) QUINCY CEMETERY				DATE 6		20c. LOCATION — City or Town, State QUINCY PA 17247					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James C. Bowerson</i>				22. NAME AND ADDRESS OF FACILITY GROVE FUNERAL HOME, INC 50 S. BROAD ST WAYNESBORO PA 17268											
23. PART I. Enter the diseasee, or complications that ceased the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cease on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in deeth) → s. ADULT RESPIRATORY DISTRESS SYNDROME DUE TO (OR AS A CONSEQUENCE OF):												2WKS			
b. CONGESTIVE HEART FAILURE DUE TO (OR AS A CONSEQUENCE OF):												2WKS			
c. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF):												2WKS			
d.															
PART II. Other significant conditions contributing to deeth but not resulting in the underlying cease given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										OTHER:			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29d. DATE SIGNED (Month, Day, Year) ► 6/4/95			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Anderson</i>		29c. LICENSE NUMBER D214571													
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ABDULL WAHEED, MD 12821 OAKHILL AVE HAGERSTOWN, MD 21740															
31. DATE FILED (Month, Day, Year) JUN 05 1995		32. REGISTRAR'S SIGNATURE <i>J. Anderson</i>													

W. H. F. 1953

DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

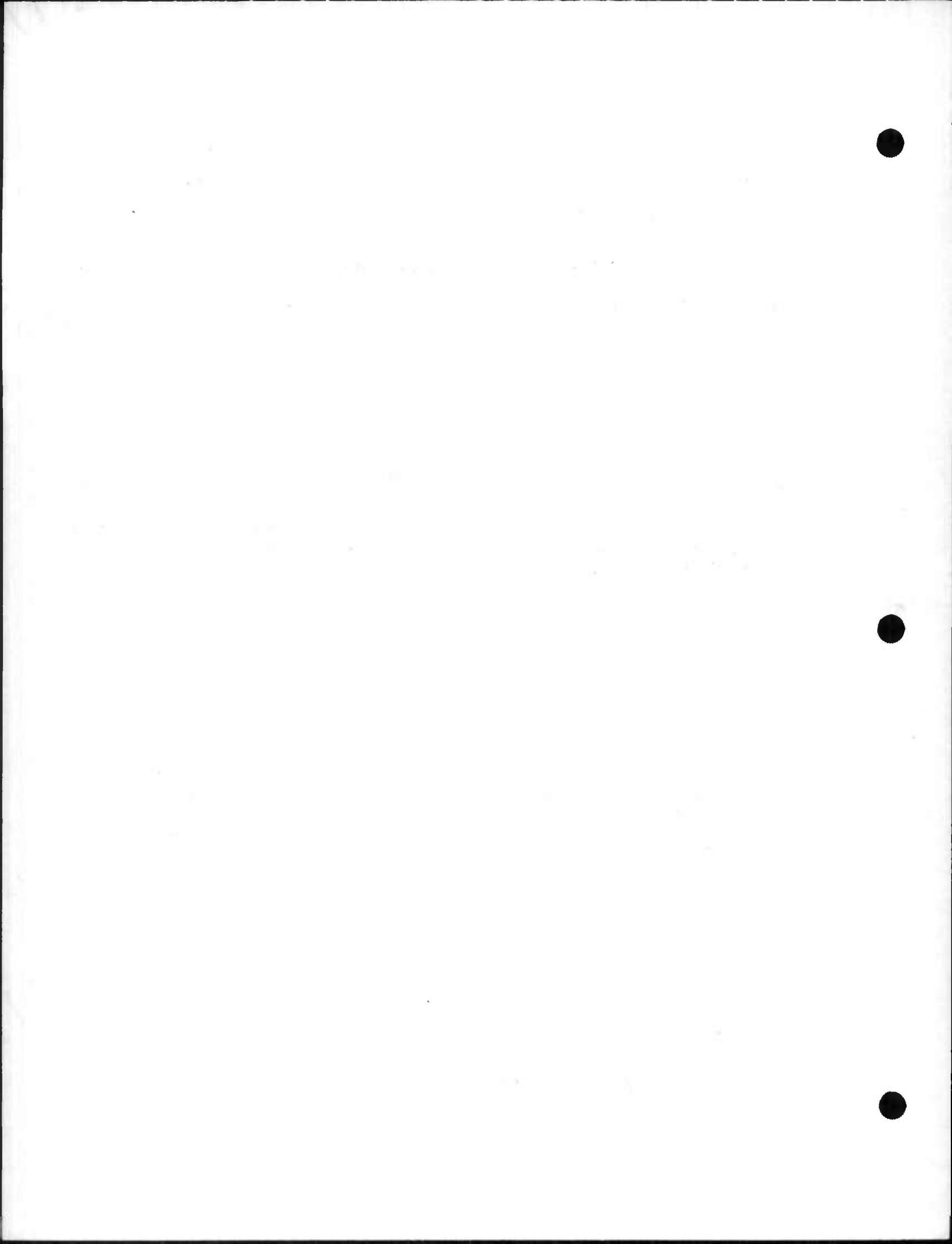
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.						
1 - FOR STATE REGISTRAR																		
1. DECEDENT'S NAME (First, Middle, Last)			Mary Evelyn Daniels				2. DATE OF DEATH MONTH JUNE DAY 1 YEAR 1995			3. TIME OF DEATH 2143 PM								
4. SOCIAL SECURITY NUMBER 213-18-9196			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 81 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Sept. 9, 1913			8. BIRTHPLACE (State or Foreign Country) Maryland				
9a. FACILITY NAME (If not institution, give street and number) Washington County Hospital			9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown												9c. COUNTY OF DEATH Washington			
RESIDENCE OF DECEDENT																		
10a. STATE Maryland		10b. COUNTY Washington			10c. CITY, TOWN OR LOCATION Hagerstown										10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 17228 Reiff Church Road						10f. ZIP CODE 21740						10g. CITIZEN OF WHAT COUNTRY? USA						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: white			14. RACE — American Indian, Black, White, etc.									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0 seamstress			16b. KIND OF BUSINESS/INDUSTRY dress mfg.												
17. FATHER'S NAME (First, Middle, Last) Clifford Angle						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Spickler												
19a. INFORMANT'S NAME (Type/Print) George Daniels						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17228 Reiff Church Rd., Hagerstown, Md. 21740												
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Broadfording Cemetery			DATE 6-5-95			20c. LOCATION — City or Town, State Hagerstown, Maryland						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sadie Minich</i>						22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740												
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.																		
IMMEDIATE CAUSE (Final disease or condition resulting in death) →																		
a. <i>Acute myocardial Infarction</i> 5 minutes DUE TO (OR AS A CONSEQUENCE OF):																		
b. <i>Anterior/erotic coronary artery</i> 15 years DUE TO (OR AS A CONSEQUENCE OF):																		
c. <i>disease - occult</i> DUE TO (OR AS A CONSEQUENCE OF):																		
d.																		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			28d. DESCRIBE HOW INJURY OCCURRED						
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			29d. DATE SIGNED (Month, Day, Year) <i>Robert Brull MD. Personal Physician 204359 6/2/95</i>															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert Brull 1459 Potomac Ave. Hagerstown</i>			32. REGISTRAR'S SIGNATURE <i>Jeanne Randall</i>															
31. DATE FILED (Month, Day, Year) JUN 5 1995																		

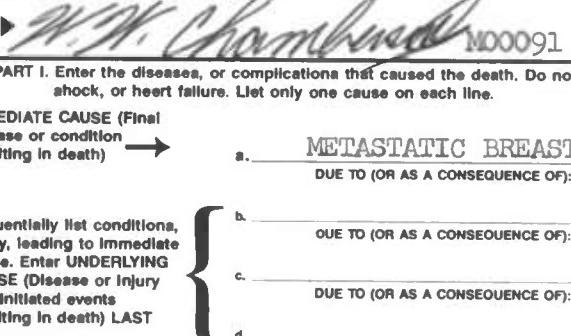
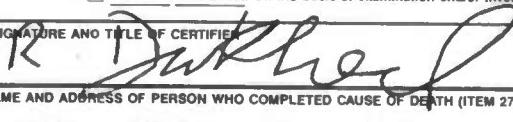
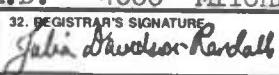


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH								REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) MARTHA DAISY DALTON								2. DATE OF DEATH MONTH JUNE DAY 10, YEAR 1995		3. TIME OF DEATH 11:30 PM	
4. SOCIAL SECURITY NUMBER 578-22-5509		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 71 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) DEC. 7, 1923		8. BIRTHPLACE (State or Foreign Country) NEW YORK	
9a. FACILITY NAME (If not institution, give street and number) MAGNOLIA GARDENS NURSING HOME								9b. CITY, TOWN OR LOCATION OF DEATH LANHAM		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE MD.		10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION HYATTSVILLE				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 6006 43rd ST.				10f. ZIP CODE 20781				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY TO THE DIRECTOR				16b. KIND OF BUSINESS/INDUSTRY CHILDRENS HOSPITAL					
17. FATHER'S NAME (First, Middle, Last) EDWARD DALTON								18. MOTHER'S NAME (First, Middle, Maiden Surname) DAISY RYERSON			
18a. INFORMANT'S NAME (Type/Print) MARGARET FARTHING								18b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 416 HUNGERFORD DR., SUITE 420, ROCKVILLE, MD. 20850			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input checked="" type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) FT. LINCOLN CEMETERY				DATE 6/14	20c. LOCATION — City or Town, State BRENTWOOD, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENCIATE  W.W. Chambers NO0091								22. NAME AND ADDRESS OF FACILITY W. W. CHAMBERS CO., RIVERDALE, MD. 20737			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death 1 YEAR	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → METASTATIC BREAST CARCINOMA a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER  Riad Dakheel		28c. LICENSE NUMBER D26492				29d. DATE SIGNED (Month, Day, Year) JUNE 11, 1995					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RIAD DAKHEEL M.D. 4000 MITCHELLVILLE RD., BOWIE, MD. 20716											
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE  John Dawson-Randall									

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DIVISION OF VITAL RECORDS, P.O. BOX 6876C, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

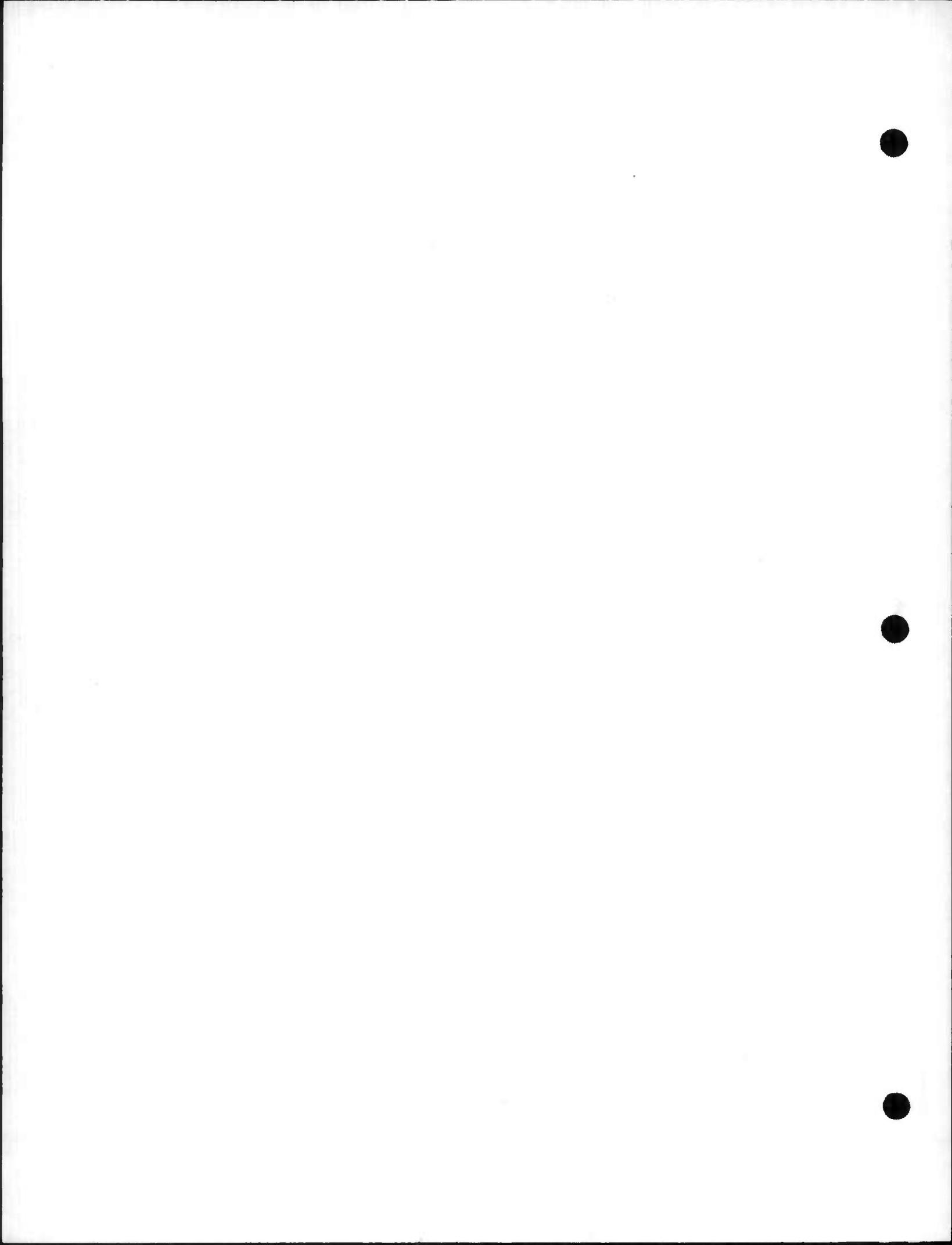
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)			2. DATE OF DEATH MONTH DAY YEAR									3. TIME OF DEATH	
Abbie M. Dorsey			June 10, 1995									5:48 P.M.	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)			8. BIRTHPLACE (State or Foreign Country)		
220-34-5352		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	76 YRS.	MONTHS	DAYS	HOURS	MIN.	July 26, 1918			Maryland		
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH									9c. COUNTY OF DEATH	
Laurel Regional Hospital			Laurel									Prince George	
RESIDENCE OF DECEASED													
10a. STATE	10b. COUNTY		10c. CITY, TOWN OR LOCATION									10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland	Howard		Jessup										
10e. STREET AND NUMBER						10f. ZIP CODE			10g. CITIZEN OF WHAT COUNTRY?				
8742 Mission Rd.,						20794			U.S.A.				
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced													
16. DECEASED'S EDUCATION (Specify only highest grade completed)			18a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			18b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 10th Grade			College (14 or 5+) Domestic			None							
17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Maiden Surname)										
Henry Moore			Mary A. Carroll										
19a. INFORMANT'S NAME (Type/Print)			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
(Husband) Mr Roger W. Dorsey -			8742 Mission Rd, Jessup, Md #20794										
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE			20c. LOCATION — City or Town, State				
			Guilford Memorial Park			6/15			Columbia, Md				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Roger R. Dorsey</i>			22. NAME AND ADDRESS OF FACILITY										
			Snowden Funeral Home P.A. 20850 246 N. Washington St, Rockville, Md										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. <i>Uro sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):													
b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):													
c. <i>hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):													
d.													
Approximate Interval Between Onset and Death Days Days Years													
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CVA, peripheral thrombolytic agent</i>													
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER <i>D28998</i>											
		29d. DATE SIGNED (Month, Day, Year) ► June 11, 1995											
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Pritam S. Saini, M.D. 9101 Cherry Lane, #211, Laurel, MD 20708</i>													
31. DATE FILED (Month, Day, Year) <i>JUN 13 1995</i>		32. REGISTRAR'S SIGNATURE <i>Jabir Shukor Randell</i>											



Amended #1, 6114195, J.W. Montgomery Co. 95 19471

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

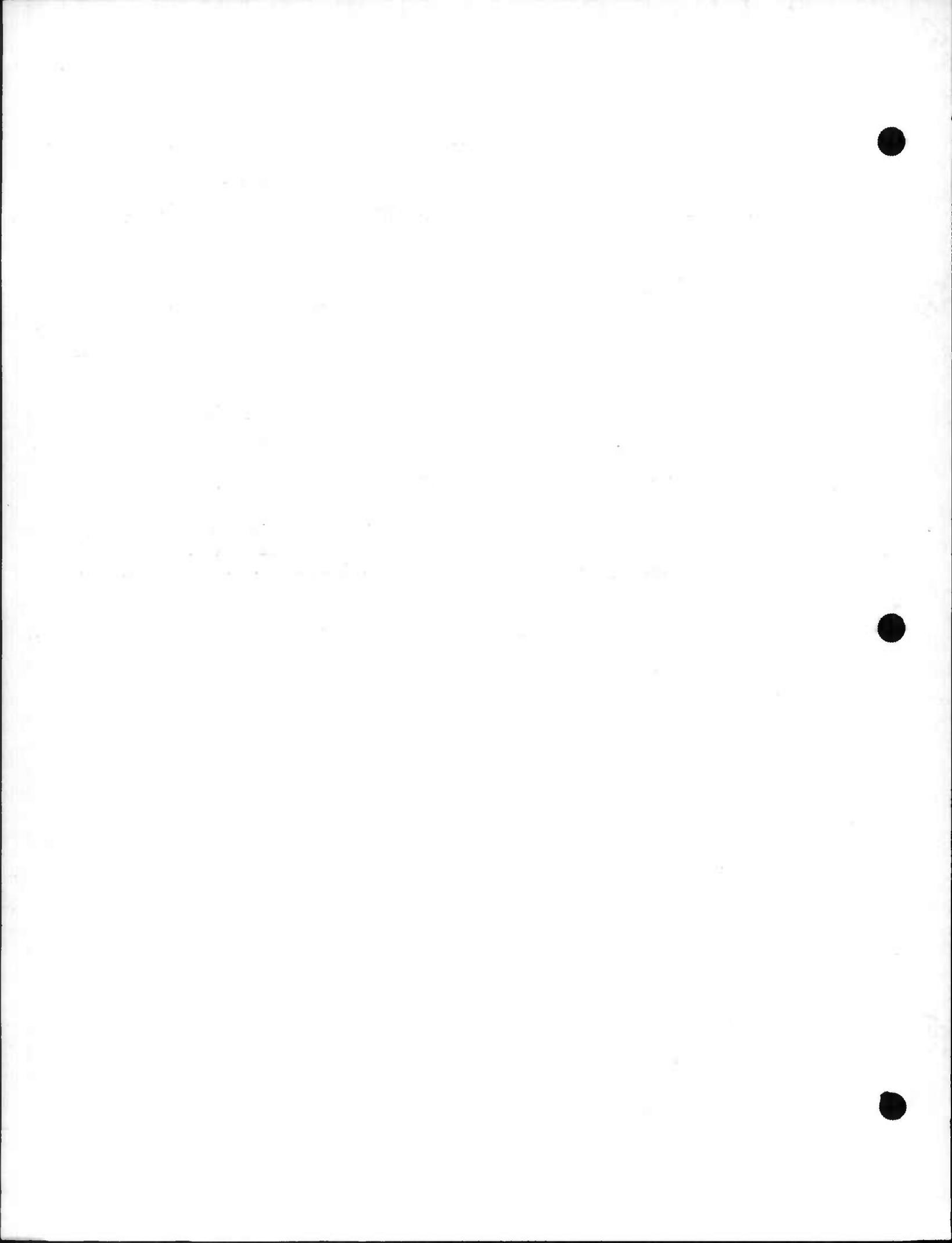
REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
		REG. NO.									
1. DECEASED'S NAME (First, Middle, Last) <i>Gerry Geraldine Grosner David DAVID</i>		2. DATE OF DEATH MONTH JUNE DAY 8 YEAR 1995		3. TIME OF DEATH 4:15 P.M.							
4. SOCIAL SECURITY NUMBER 579-28-4247		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS		MIN.	
8a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL		8b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		8c. COUNTY OF DEATH MONTGOMERY		8d. DATE OF BIRTH (Month, Day, Year) NOV. 20. 1921		8e. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.			
RESIDENCE OF DECEASED											
10a. STATE MARYLAND		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION BETHESDA		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 8506 BRADMOOR DRIVE				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME							
17. FATHER'S NAME (First, Middle, Last) GERALD DAVID GROSNER		18. MOTHER'S NAME (First, Middle, Maiden Surname) ADA STROUSE									
19a. INFORMANT'S NAME (Type/Print) Joanne David Herrera		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8506 BRADMOOR DR. BETHESDA, MD. 20817									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WASHINGTON HEBREW CONG. MEM.		DATE 6/12		20c. LOCATION — City or Town, State WASHINGTON, D.C.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Levone Simmons</i>		22. NAME AND ADDRESS OF FACILITY JOSEPH GAWLER'S SONS, INC. 20016 5130 WISCONSIN AVE. N.W. WASHINGTON, D.C.									
23. PART I Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death 4 days					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. _____ DUE TO (OR AS A CONSEQUENCE OF):	c. _____ DUE TO (OR AS A CONSEQUENCE OF):	d. _____ DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetic ketoacidosis				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amendments</i> MD		29c. LICENSE NUMBER D38262		29d. DATE SIGNED (Month, Day, Year) June 9, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ANURITA MENDHIRATTA 2401 Research BLVD Rockville MD 20854											
31. DATE FILED (Month, Day, Year) JUN 14 1995		32. REGISTRAR'S SIGNATURE <i>July 14 1995</i>									

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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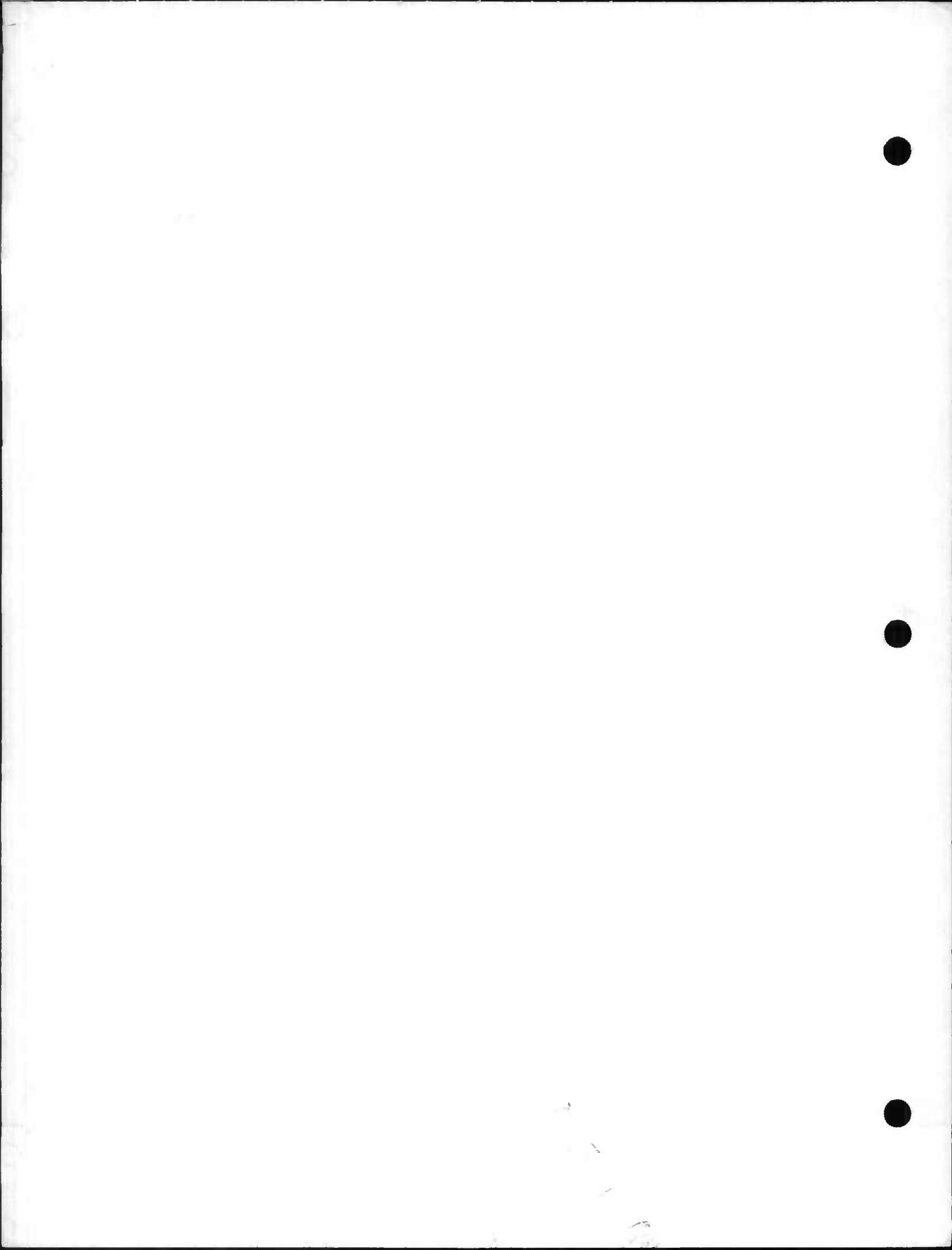
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Blanche Hanna DiBella										2. DATE OF DEATH MONTH June DAY 13 YEAR 1995	3. TIME OF DEATH 6:02 PM
4. SOCIAL SECURITY NUMBER 578-56-8390		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 94 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN. 0		7. DATE OF BIRTH (Month, Day, Year) August 27, 1900		8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) Holy Cross Hospital										9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring	9c. COUNTY OF DEATH Montgomery
10a. STATE N/A		10b. COUNTY N/A		10c. CITY, TOWN OR LOCATION Washington, D.C.				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER 5766 Sherrier Place, N.W.					10f. ZIP CODE 20016			10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY Beautician			Self Employed			
17. FATHER'S NAME (First, Middle, Last) Graves					18. MOTHER'S NAME (First, Middle, Maiden Surname) Sophie Hunter						
19a. INFORMANT'S NAME (Type/Print) Joan Ellen DiBella					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1109 Dryden St., Silver Spring, MD 20901						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) Metropolitan Crematory		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) 6/15/95			DATE 6/15/95		20c. LOCATION — City or Town, State Alexandria, VA				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy G. Campbell</i>					22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary artery disease DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death 10 years											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Dementia											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) 4. Nursing Home									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29d. DATE SIGNED (Month, Day, Year) ► 6/18/95				
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John D. Wilson, M.D.</i>					29c. LICENSE NUMBER 043237						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 14201 Laurel PK Dr #102 Laurel, MD 20707											
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE <i>John D. Wilson, M.D.</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

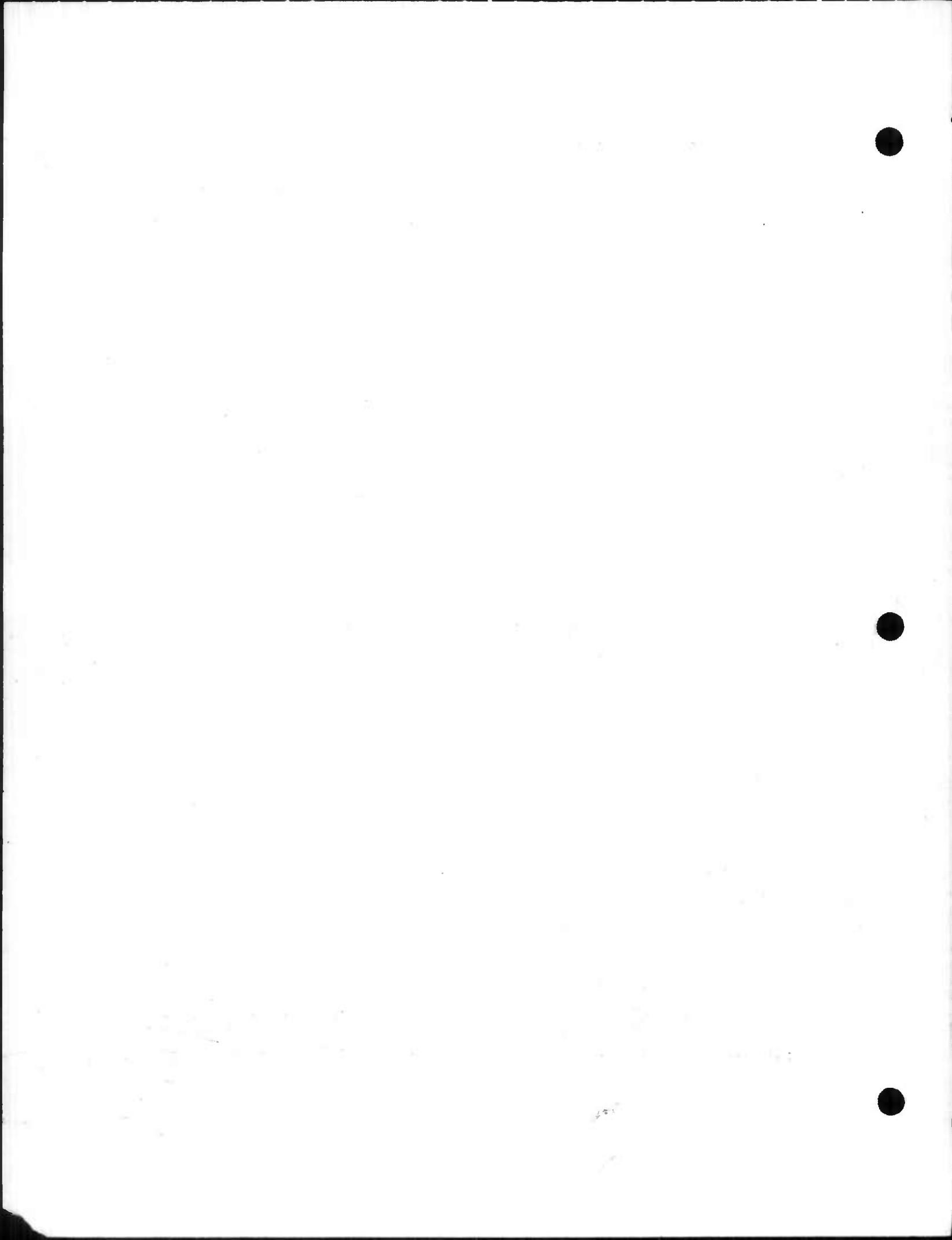
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19473

1. DECEDENT'S NAME (First, Middle, Last) Catherine Mary Dalton					2. DATE OF DEATH MONTH DAY YEAR 06 14 1995	3. TIME OF DEATH 5:55 P M
4. SOCIAL SECURITY NUMBER 032-09-5462		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) Nov. 11, 1909	
9a. FACILITY NAME (If not institution, give street and number) Villa Rosa Nursing Home		9b. CITY, TOWN OR LOCATION OF DEATH Mitchellville			8. BIRTHPLACE (State or Foreign Country) Massachusetts	
9c. COUNTY OF DEATH Prince Georges						
RESIDENCE OF DECEDENT						
10a. STATE Maryland	10b. COUNTY Prince Georges	10c. CITY, TOWN OR LOCATION Clinton			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 9113 Susan Lane			10f. ZIP CODE 20735		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES College (1-4 or 5+)			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Educator			16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Daniel J. Dunn				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Frances LaSalle		
19a. INFORMANT'S NAME (Type/Print) Catherine Eileen Parker			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9113 Susan Lane, Clinton, MD 20735			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) St. John's Cemetery		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, Crematory or other place) St. John's Cemetery		DATE 6/19/95	20c. LOCATION — City or Town, State Silver Spring, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Timothy G. Campbell						
22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr.MD 20901						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						
IMMEDIATE CAUSE (Final disease or condition resulting in death) →						
a. Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):						
b. Lymphoma DUE TO (OR AS A CONSEQUENCE OF):						
c. DUE TO (OR AS A CONSEQUENCE OF):						
d.						
Approximate Interval Between Onset and Death 6/14/95 10/90						
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia Aspiration						
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER Rakesh Arora, MD		29c. LICENSE NUMBER D 20108		29d. DATE SIGNED (Month, Day, Year) 6/14/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RAKESH ARORA, MD, 14300 GALLANT FOX LN #222 BOWIE MD 20715						
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE Juliann Dalton-Harday				



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

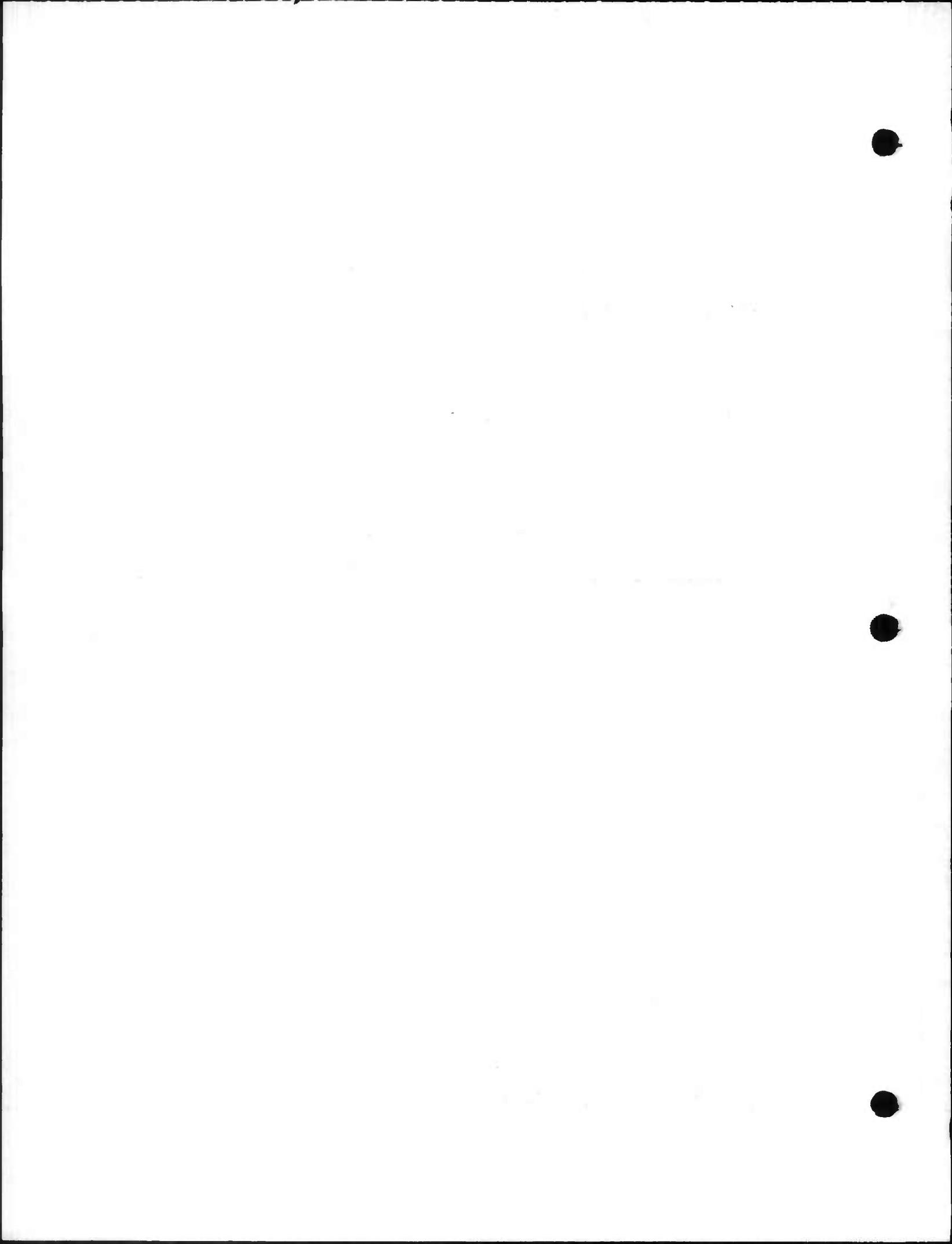
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
Edward Donald Elmore											6-10-95	1:30 a.m.
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTHN (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)				
213-64-0466		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	42 YRS.	MONTHS	DAYS	3-2-53		Maryland				
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH				
57 Robinson Landing Road				Severna Park				Anne Arundel				
10e. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?				
Maryland		Anne Arundel		Severna Park				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?				
57 Robinson Landing Road				21146				USA				
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white				
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced												
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+)			Realtor			Real Estate				
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)								
Francis Nelson Elmore				Agnes Collins								
19e. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)								
Deirdre Elmore				Same as # 10								
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) .				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place)			DATE	20c. LOCATION — City or Town, State				
				Lakemont Cemetery			6-13-95	Davidsonville, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert Beaman</i>				22. NAME AND ADDRESS OF FACILITY Barranco and Sons Funeral Home 495 Ritchie Hwy Severna Park MD 21146								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Ventricular arrhythmias</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Myocardial infarction</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>											1 minute? 6 days	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
		28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kevin Doyle MD</i>		29c. LICENSE NUMBER D 31122				29d. DATE SIGNED (Month, Day, Year) ► 6/14/95						
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN DOYLE, M.D. 203 Hospital Dr. Suite 206 GLEN BURNIE MD 21061												
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE <i>Juliann Stuckey Randall</i>										

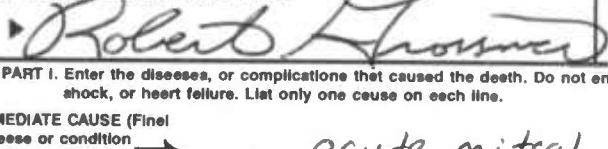
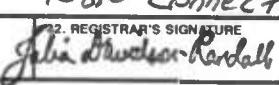


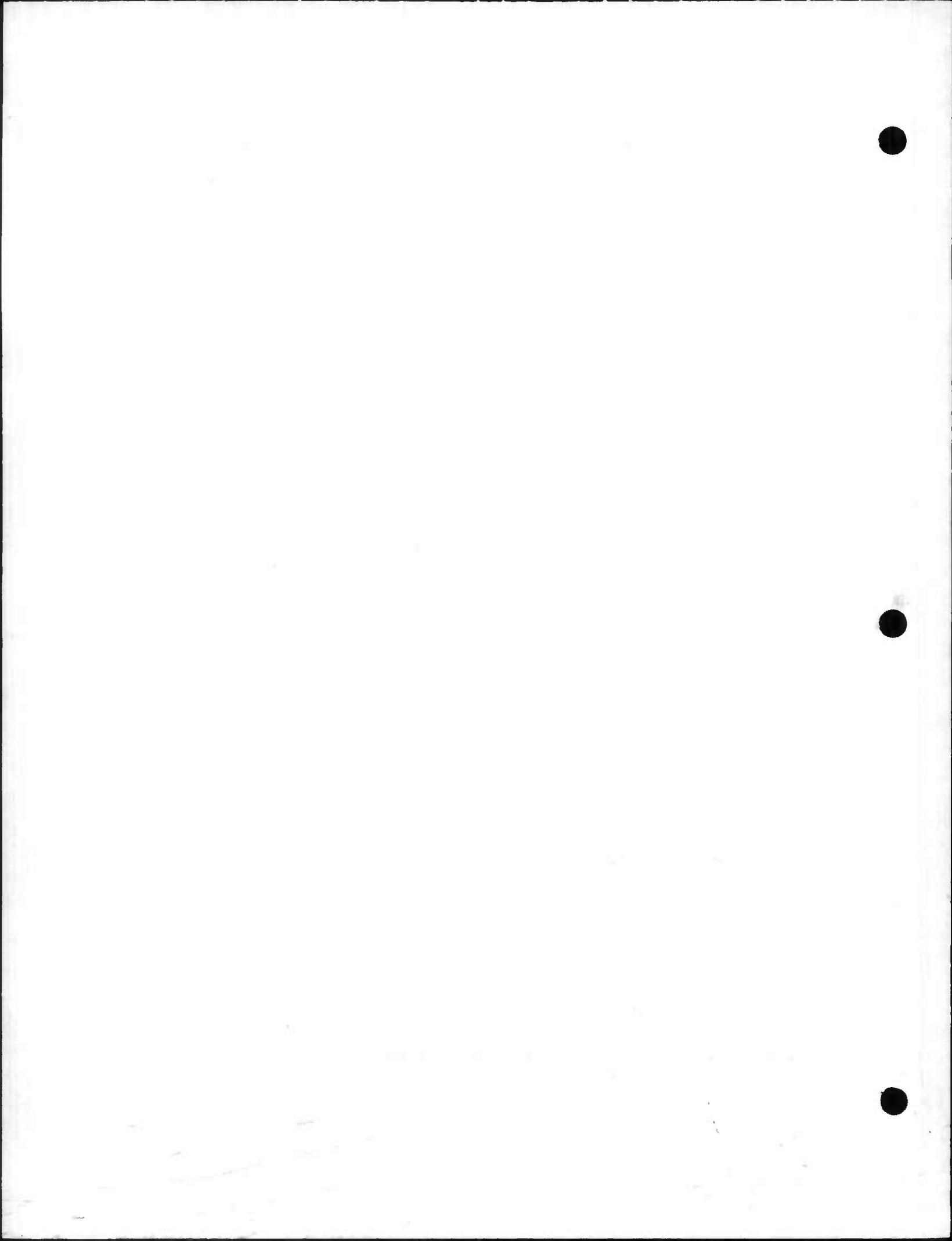
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.					
1. DECEASED'S NAME (First, Middle, Last)		Eugene Allen Ehrlich						2. DATE OF DEATH MONTH		YEAR					
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		3. TIME OF DEATH					
055-16-6392		<input checked="" type="checkbox"/> M <input type="checkbox"/> F		77 YRS.		MONTHS		DAYS		HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH						7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)					
HOLY CROSS HOSPITAL		SILVER SPRING						APR. 10, 1918		NEW YORK					
RESIDENCE OF DECEASED															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
MARYLAND		MONTGOMERY		SILVER SPRING											
10e. STREET AND NUMBER		10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?							
1903 DENNIS AVE.		20902						UNITED STATES							
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II						13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)						16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12)		College (1-4 or 5+)						MILITARY PLANNER				FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)													
MAXWELL EHRLICH		ESTELLE WEISS													
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
ALMA EHRLICH (WIFE)		1903 DENNIS AVE. SILVER SPRING, MD 20902													
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)						DATE		20c. LOCATION — City or Town, State					
<input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)								MT. COMFORT 6-12		ALEXANDRIA, VIRGINIA					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 															
22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC 1170 ROCKVILLE PIKE ROCKVILLE, MD 20852															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.															
IMMEDIATE CAUSE (Final disease or condition resulting in death) →															
a. acute mitral regurgitation DUE TO (OR AS A CONSEQUENCE OF):															
b. fungal endocarditis DUE TO (OR AS A CONSEQUENCE OF):															
c. DUE TO (OR AS A CONSEQUENCE OF):															
d. DUE TO (OR AS A CONSEQUENCE OF):															
Approximate Interval Between Onset and Death															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. gastric carcinoma															
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH		1 <input checked="" type="checkbox"/> Natural		5 <input type="checkbox"/> Pending Investigation		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
		2 <input type="checkbox"/> Accident		3 <input type="checkbox"/> Suicide		4 <input type="checkbox"/> Homicide									
						28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)		1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		Roy Fried, MD 10810 Connecticut Ave, Kensington, MD 20895						D34590				► 6/9/95			
31. DATE FILED (Month, Day, Year)		JUN 13 1995						32. REGISTRAR'S SIGNATURE 				DHMH-16 Rev 1/89			



DIVISION OF VITAL RECORDS, P.O. BOX 68760

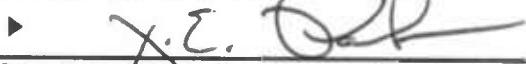
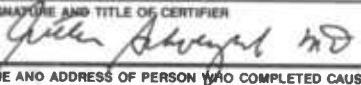
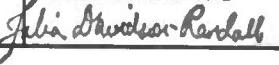
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

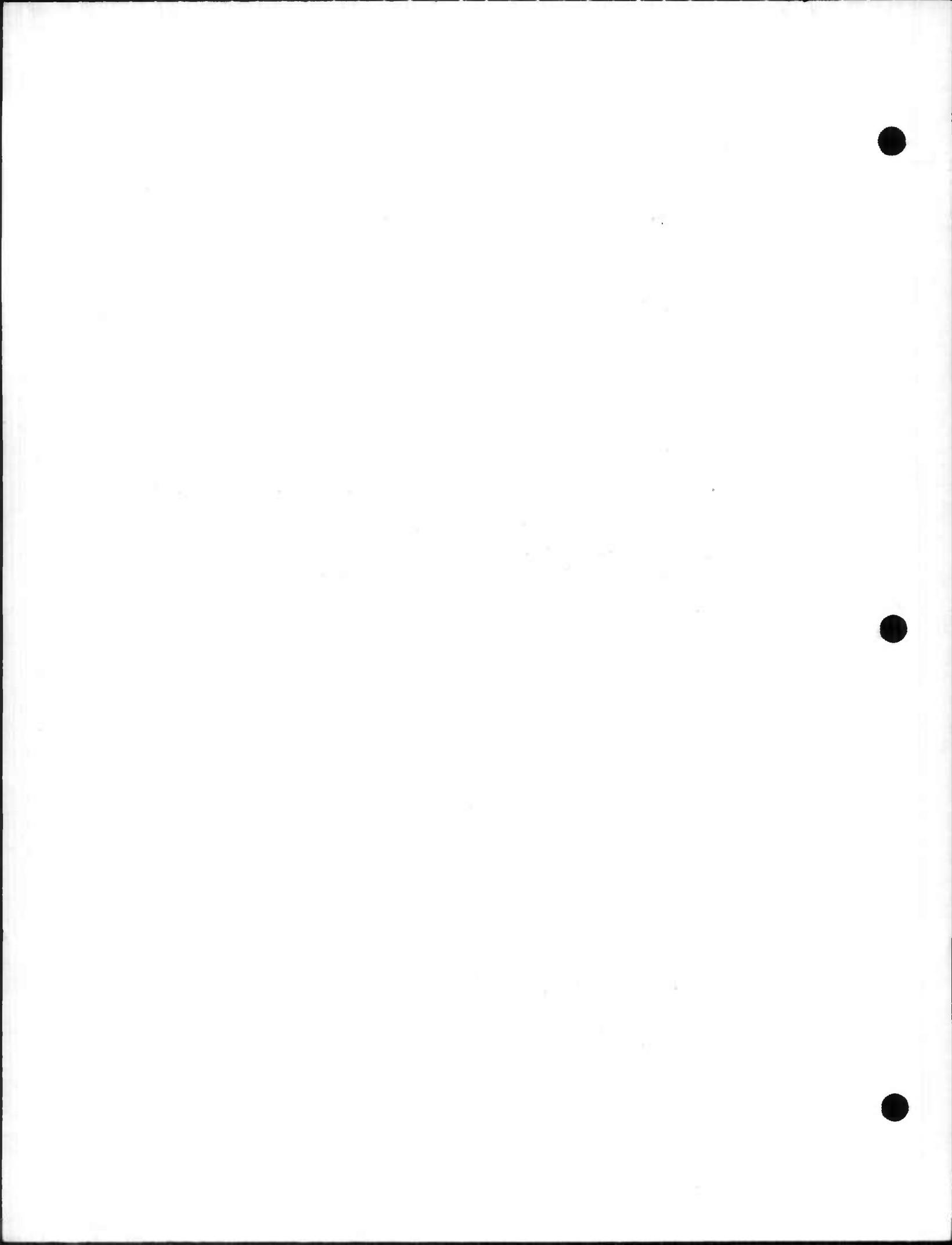
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)		EDWARDS								2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
AMY Geraldine										JUNE 08 1995	0625 AM	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)	
577-01-1445		<input type="checkbox"/> M <input checked="" type="checkbox"/> F		89 YRS.		MONTHS DAYS		HOURS MIN.		Apr. 8, 1906	Maryland	
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH								9c. COUNTY OF DEATH		
Shady Grove Adventist Hospital		Rockville								Montgomery		
RESIDENCE OF DECEASED												
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
Maryland		Montgomery		Gaithersburg								
10e. STREET AND NUMBER		10f. ZIP CODE								10g. CITIZEN OF WHAT COUNTRY?		
102 Rolling Road		20877								United States		
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced												
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY						
Elementary/Secondary (0-12) 12		College (1-4 or 5+) Operator								Telephone Company		
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)										
John Thomas Phoebus		Aggie C. English										
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Ronald L. Phoebus		102 Rolling Road, Gaithersburg, Maryland 20877										
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Forest Oak Cemetery				DATE		20c. LOCATION — City or Town, State		6/9 Gaithersburg, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY DeVol Funeral Home										
		10 E. Deer Park Drive, Gaithersburg, MD										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												
Approximate Interval Between Onset and Death												
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. Pneumonia								24 hours		
		DUE TO (OR AS A CONSEQUENCE OF): Dehydration								48 hours		
		b. Diabetes								4 years		
		DUE TO (OR AS A CONSEQUENCE OF): d.										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
Coronary artery disease, Cerebrovascular accident Hyper tension, Hip replacement												
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				OTHER:		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER D18726		29d. DATE SIGNED (Month, Day, Year) ► June 8, 1995				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)												
9715 Medical Center Drive, Rockville, MD 20850												
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE 										
JUN 15 1995												



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

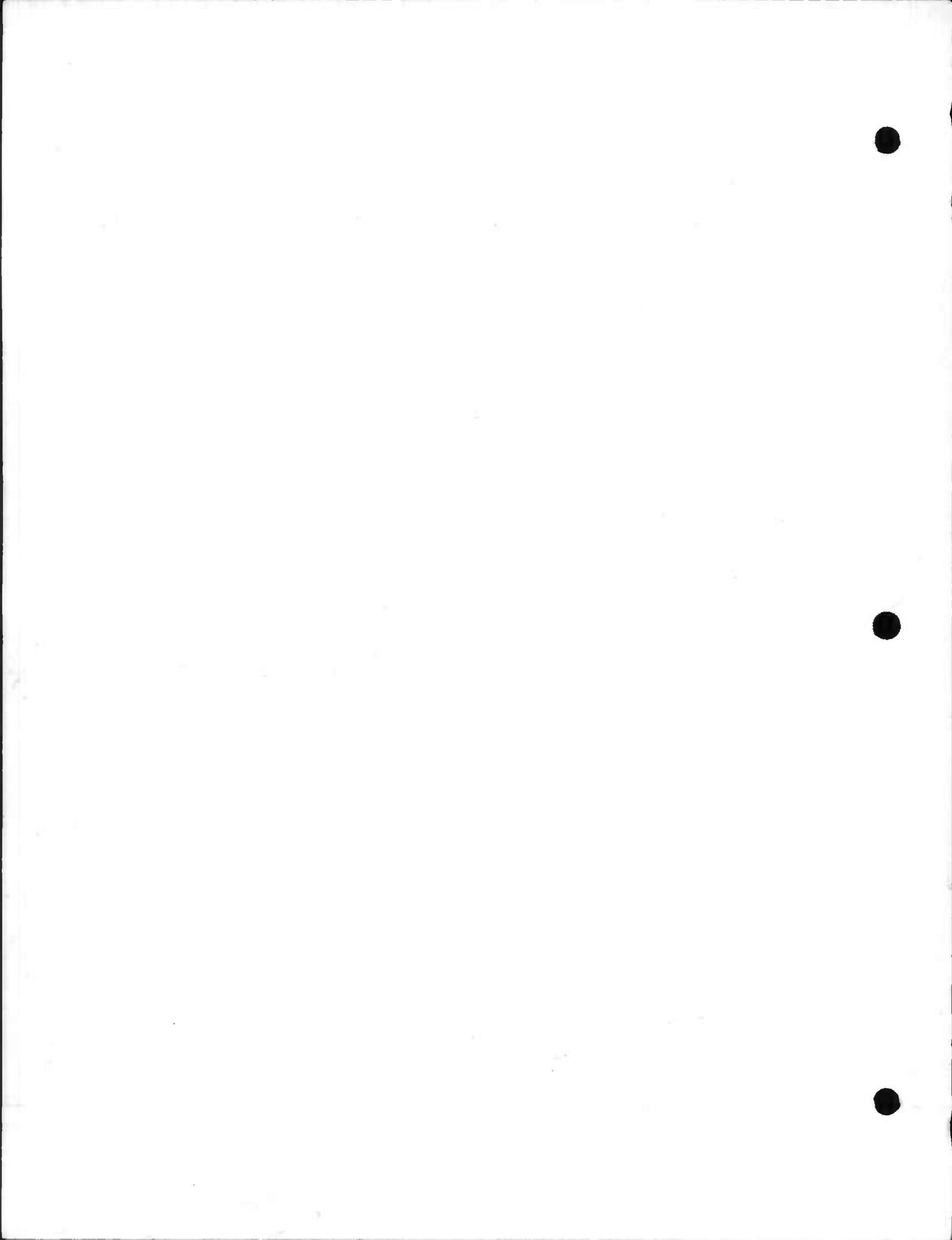
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19477

1. DECEASED'S NAME (First, Middle, Last)		ENDELMAN				2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
YETTA						June 5 1995	9 A.M.
4. SOCIAL SECURITY NUMBER 065-18-2247D		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 101 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Mar 17 1894	8. BIRTHPLACE (State or Foreign Country) Russia
9a. FACILITY NAME (If not institution, give street and number) Hebrew Home Of Greater Washington				9b. CITY, TOWN OR LOCATION OF DEATH Rockville		9c. COUNTY OF DEATH Montgomery	
RESIDENCE OF DECEASED							
10a. STATE MD	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Rockville				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 6121 Montrose Road				10f. ZIP CODE 20852		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		
14. RACE — American Indian, Black, White, etc. Specify: white							
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) gradeschool		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Seamstress			16b. KIND OF BUSINESS/INDUSTRY Private		
17. FATHER'S NAME (First, Middle, Last) Hillel Glowatsky				18. MOTHER'S NAME (First, Middle, Maiden Surname) Chana (Unknown)			
19a. INFORMANT'S NAME (Type/Print) Harry Endelman				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9308 Weaver Street Silver Spring MD 20901			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) @ King David Memorial Gardens			DATE 6-7	20c. LOCATION — City or Town, State Falls Church VA	
21. SIGNATURE OF FUNERAL SERVICE LICENSER 				22. NAME AND ADDRESS OF FACILITY Edward Sagel Funeral Direction 1091 Rockville Pike Rockville MD 20852			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ISCHEMIC CARDIOMYOPATHY</i> DUE TO (OR AS A CONSEQUENCE OF):							
b. <i>CORONARY ARTERY DISEASE</i> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Approximate Interval Between Onset and Death YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> <input type="checkbox"/> Homicide <input type="checkbox"/> 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward J. Attending Physician</i>				29c. LICENSE NUMBER D18084		29d. DATE SIGNED (Month, Day, Year) 06/05/95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27, Type/Print) D.D. PATEL MD 6121 Montrose Rd, Rockville MD 20852							
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE <i>Julia Shuler-Randall</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

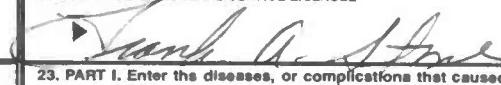
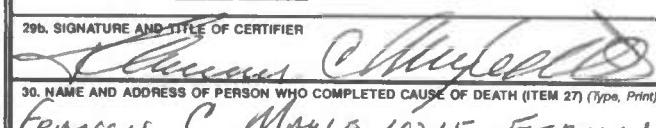
TO BE COMPLETED BY FUNERAL DIRECTOR

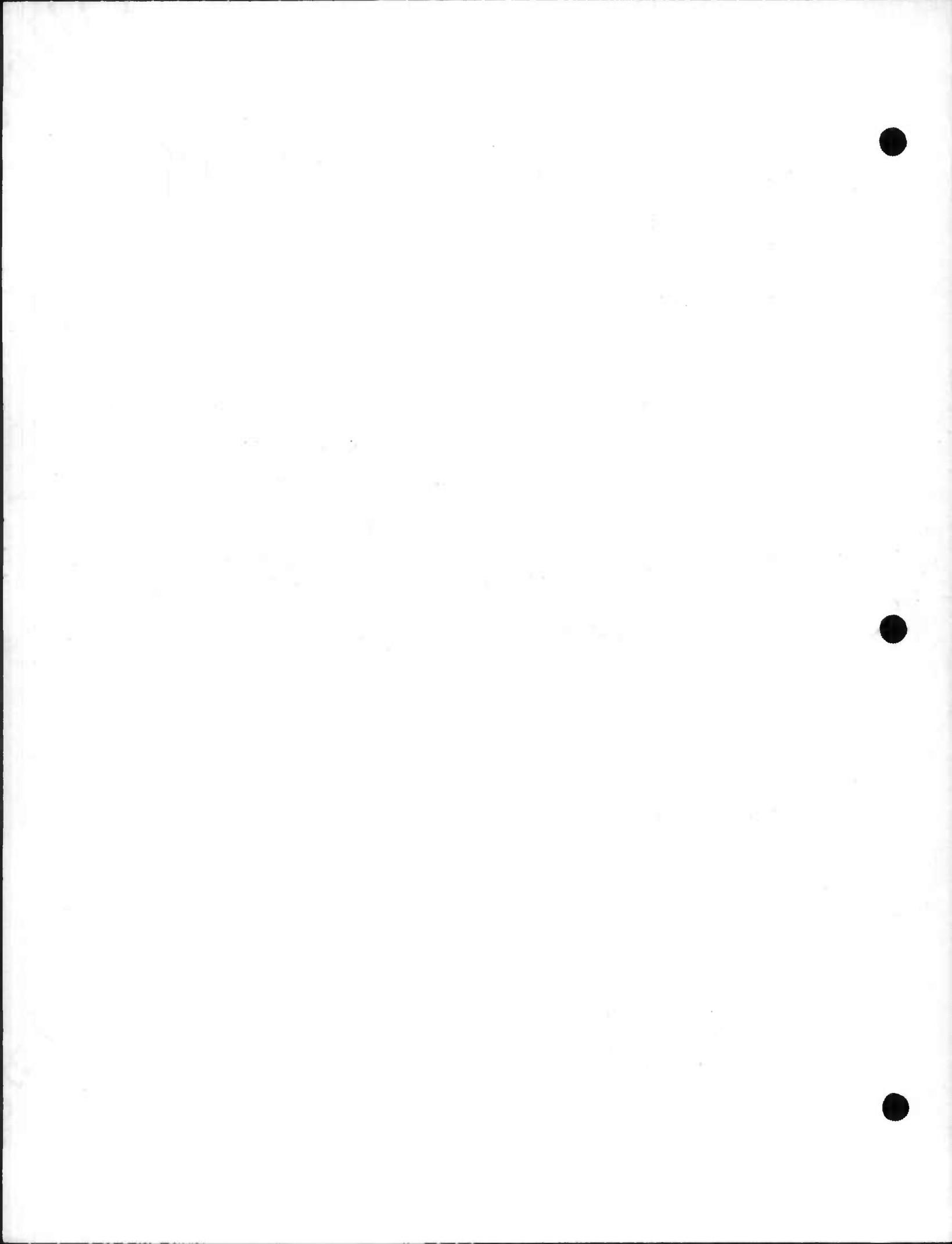
1.

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19478

1. DECEASED'S NAME (First, Middle, Last)		ESTRIN				2. DATE OF DEATH MONTH JUNE DAY 9 YEAR 95 21:05 PM	3. TIME OF DEATH
4. SOCIAL SECURITY NUMBER 360-01-9871		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
9a. FACILITY NAME (If not institution, give street and number) SUBURBAN HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA				9c. COUNTY OF DEATH MONTGOMERY	
RESIDENCE OF DECEASED							
10a. STATE MARYLAND	10b. COUNTY MONTGOMERY	10c. CITY, TOWN OR LOCATION BETHESDA				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 7228 SWANSONG WAY				10f. ZIP CODE 20817		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) C-4		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHEMIST		16b. KIND OF BUSINESS/INDUSTRY US FEDERAL GOVERNMENT			
17. FATHER'S NAME (First, Middle, Last) DAVID ESTRIN				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH WEINER			
19a. INFORMANT'S NAME (Type/Print) POLLY ESTRIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7228 SWANSONG WAY BETHESDA, MARYLAND 20817			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) COGN. B'NAT YAKOV CEMETERY		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, town, state, date, place)		DATE 6/12		20c. LOCATION — City or Town, State COOK, ILLINOIS	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY DANZANSKY-GOLDBERG MEMORIAL CHAPELS INC. 1170 ROCKVILLE PIKE ROCKVILLE MARYLAND 20850			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDIAL INFARCTION DUE TO (OR AS A CONSEQUENCE OF): b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER 007099		29d. DATE SIGNED (Month, Day, Year) JUN 10 95	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANCIS C MCALE 10215 FERNWOOD RD BETHESDA MD 20817							
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE Julie Dawson-Randall					



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

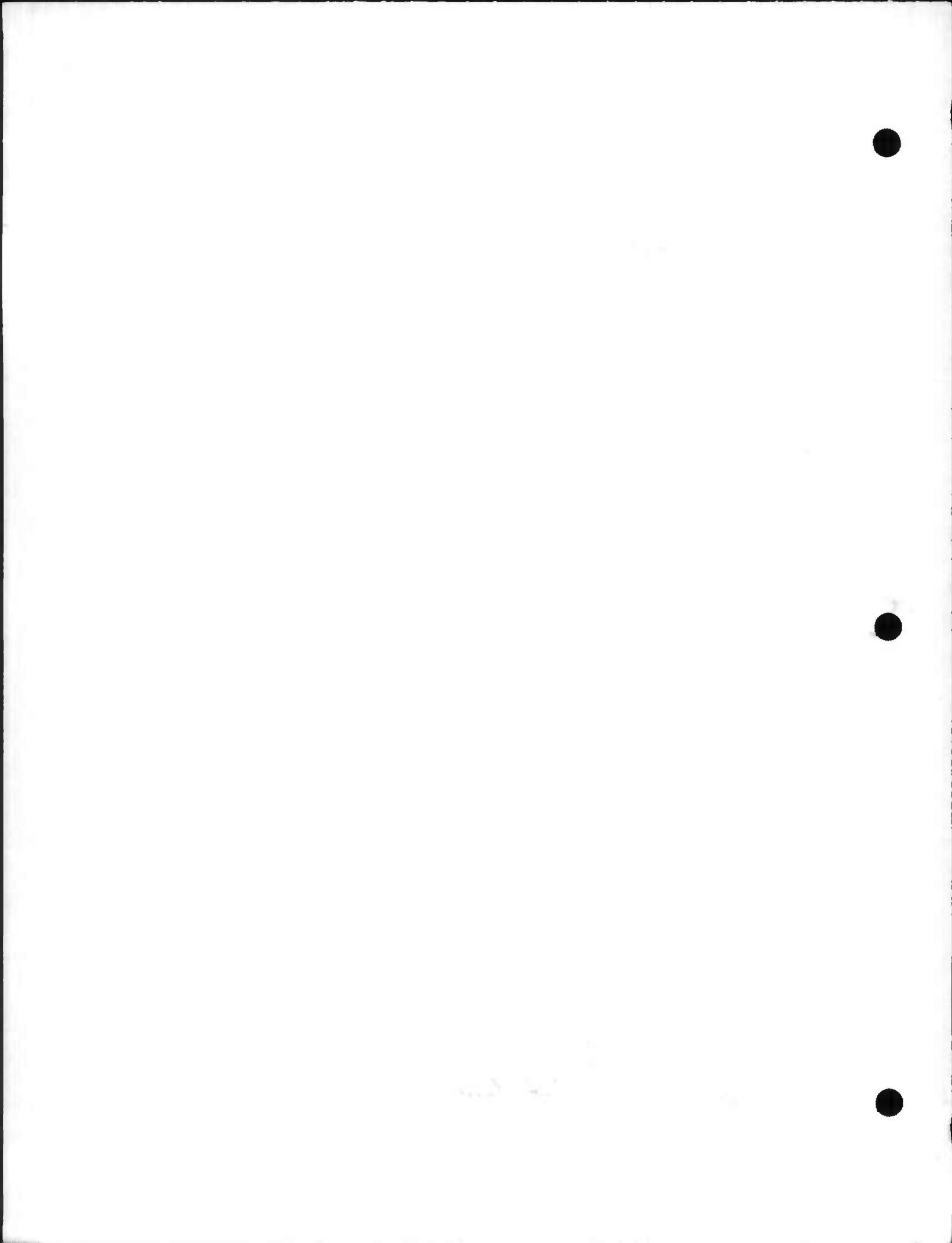
IMPORTANT: If Item 28 is marked, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1 - FOR STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 16 1995										3. TIME OF DEATH 12:20 p.m. M	
1. DECEDENT'S NAME (First, Middle, Last) Dorothea NMN FUNK													
4. SOCIAL SECURITY NUMBER 216-40-2190		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 4 1905		8. BIRTHPLACE (State or Foreign Country) New York			
9a. FACILITY NAME (If not institution, give street and number) Asbury Methodist Village												9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg	9c. COUNTY OF DEATH Montgomery
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Gaithersburg								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER Asbury Methodist Home												10f. ZIP CODE 20877	10g. CITIZEN OF WHAT COUNTRY? U.S.A.
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 0				16b. KIND OF BUSINESS/INDUSTRY Homemaker							
17. FATHER'S NAME (First, Middle, Last) (Unknown) Cupp						18. MOTHER'S NAME (First, Middle, Maiden Surname) Unknown							
19a. INFORMANT'S NAME (Type/Print) Dolores Funk						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 162 Hagerstown, Maryland 21740							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hagerstown Crematory 6-18-95						DATE	20c. LOCATION — City or Town, State Hagerstown, Maryland
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Scott H. Minich</i>						22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home							
						415 E. Wilson Blvd. Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. <i>sepsis</i>													
b. <i>Bacterial sepsis</i>													
c. <i>pneumonia</i>													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>coronary artery disease</i> <i>other than brain tumor</i>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF DATE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Elliott R. Goldstein</i>		29c. LICENSE NUMBER DOB3518		29d. DATE SIGNED (Month, Day, Year) 6/16/95									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Elliott R. Goldstein 9410 Old Georgetown Road, Bethesda, MD													
31. DATE FILED (Month, Day, Year) JUN 20 1995		32. REGISTRAR'S SIGNATURE <i>Julie Shuster Harrell</i>											

95 19479



DIVISION OF VITAL RECORDS, P.O. BOX 68760

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

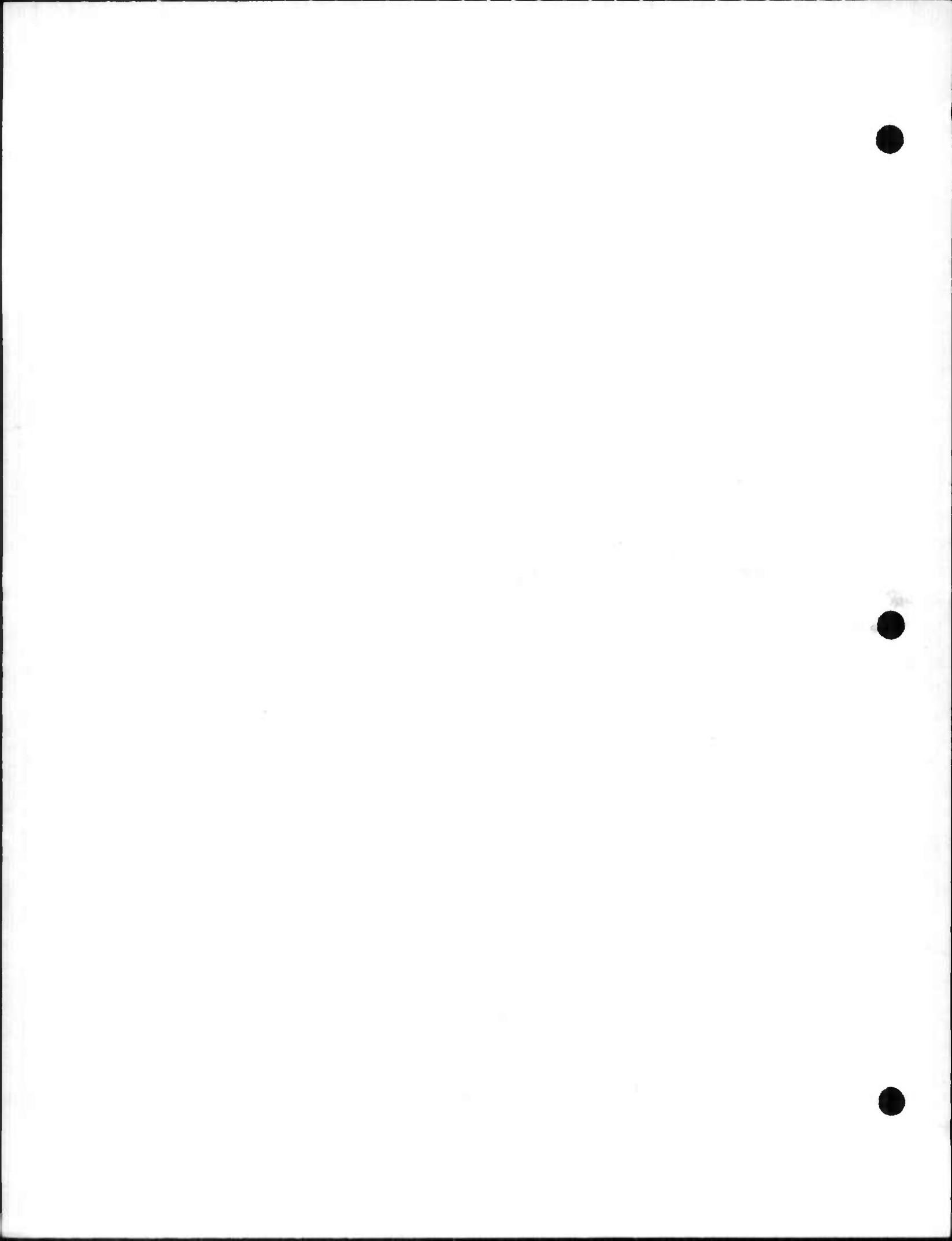
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		FLORA LENA FRENEY								2. DATE OF DEATH MONTH JUNE DAY 8, 1995 YEAR	3. TIME OF DEATH 8:45 M
4. SOCIAL SECURITY NUMBER 212-10-8947		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS				7. DATE OF BIRTH (Month, Day, Year) May 22, 1914	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) 7245 Athol Rd.		9b. CITY, TOWN OR LOCATION OF DEATH Quantico								9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Wicomico	10c. CITY, TOWN OR LOCATION Quantico								10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER 7245 Athol Rd.				10f. ZIP CODE 21856				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (14 or 5+) Seamstress				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Latimer		18. MOTHER'S NAME (First, Middle, Maiden Surname) Phillips				19. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7245 Athol Rd., Quantico, MD 21856					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION /Name of cemetery, crematory or other place/ Springhill Memory Gardens				DATE 6/10		20c. LOCATION — City or Town, State Hebron, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jean M. Kellogg</i>		22. NAME AND ADDRESS OF FACILITY Holloway Funeral Home 501 Snow Hill Rd., Salisbury, MD 21801									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) → b. <i>MYOCARDIAL INFARCTION</i> DUE TO (OR AS A CONSEQUENCE OF):											
Approximate Interval Between Onset and Death											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>CONGESTIVE HEART FAILURE</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen H. Laffey MD</i>		29c. LICENSE NUMBER 820683				29d. DATE SIGNED (Month, Day, Year) ► 6/9/95					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>STEPHEN H. LAFFEY MD, PO Box 121 NANTICOKE MD 21840</i>											
31. DATE FILED (Month, Day, Year) JUN 09 1995		32. REGISTRAR'S SIGNATURE <i>Juli A. Wilson Randall</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

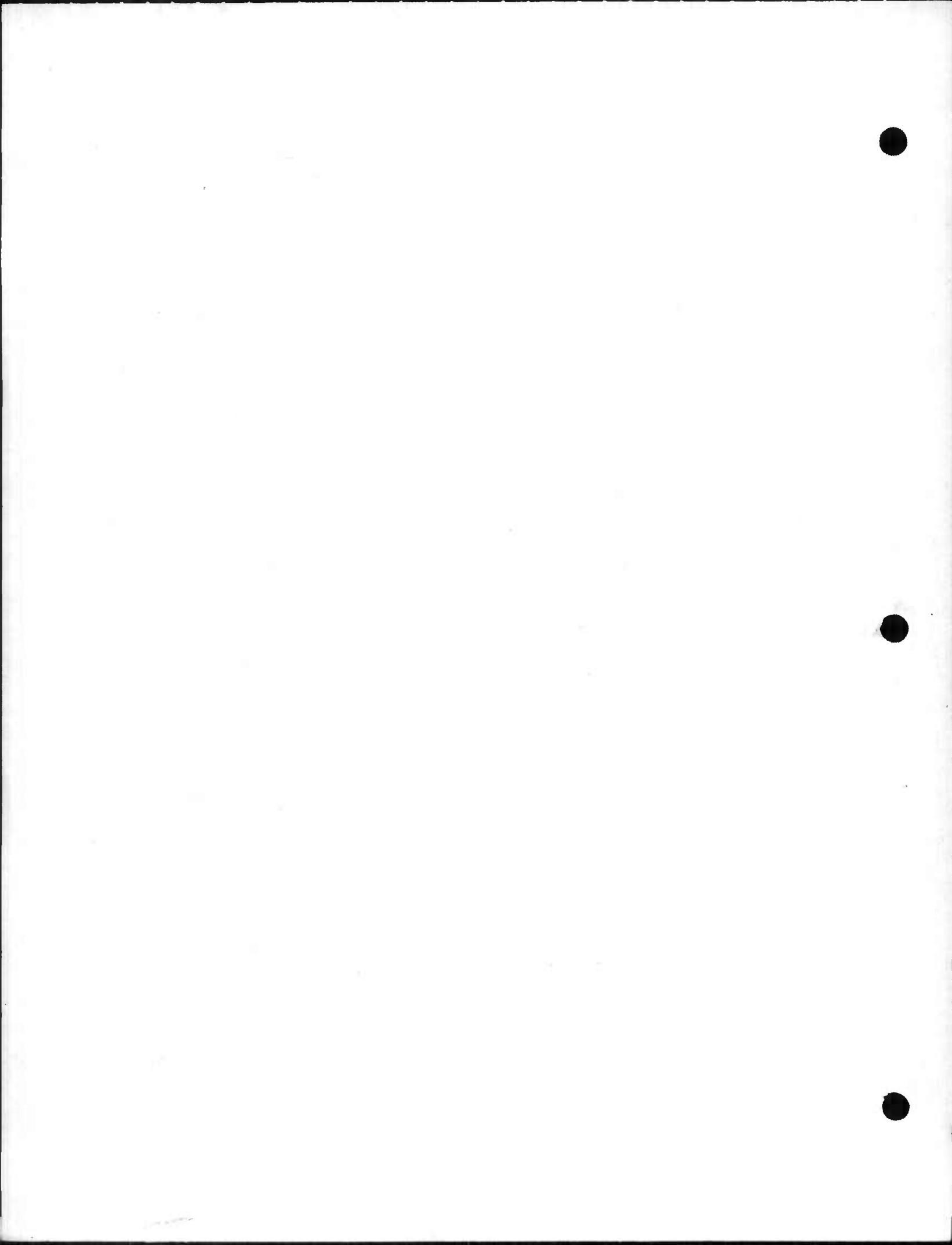
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19481

1. DECEASED'S NAME (First, Middle, Last)		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH HOUR MIN.	
Gladys Caroline Feily		June 11 1995		8:20 PM	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday) YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.
473-30-4862		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	79		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
Vantage House		Columbia		Howard	
RESIDENCE OF DECEASED					
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
Maryland	Howard	Columbia			<input type="checkbox"/>
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?	
5400 Vantage Point Road		21044		U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify	
Elementary/Secondary (0-12)		College (1-4 or 8+)		14. RACE — American Indian, Black, White, etc. Specify: White	
4		Homemaker			
15. DECEASED'S EDUCATION (Specify only highest grade completed)			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		
Elementary/Secondary (0-12)			16b. KIND OF BUSINESS/INDUSTRY Own Home		
17. FATHER'S NAME (First, Middle, Last)			18. MOTHER'S NAME (First, Middle, Maiden Surname)		
Alex D. Nelson			Wilhemina Sandberg		
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
John H. Feily		10074 Carillon Drive Ellicott City, Maryland 21042			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE	20c. LOCATION — City or Town, State Minneapolis, Minnesota
		Lakewood Cemetery		6/17/95	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Steven Stine			22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd., W. Sil. Spr., MD 20901		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →					
<p>a. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Serous pleuritis</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Atherosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. _____</p>					
Approximate Interval Between Onset and Death Days Years Years					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>_____</p>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER 022856			
29b. SIGNATURE AND TITLE OF CERTIFIER John Stine		29d. DATE SIGNED (Month, Day, Year) June 12, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jerry L. Levine, MD 11055 Little River Rd Columbia, Md 21044					
31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE John Stine			



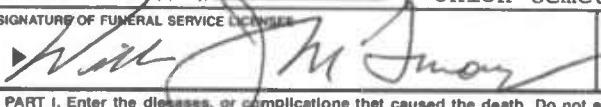
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or if item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED'S NAME (First, Middle, Last) Taylor William Gibson										2. DATE OF DEATH MONTH June DAY 18 , 1995 YEAR	3. TIME OF DEATH 6:24 p.m.
4. SOCIAL SECURITY NUMBER 226-08-3655		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 34 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. HOURS 0	MIN. 0	7. DATE OF BIRTH (Month, Day, Year) April 16, 1961	8. BIRTHPLACE (State or Foreign Country) Virginia			
9a. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Frederick			9c. COUNTY OF DEATH Frederick				
10e. STATE Virginia	10b. COUNTY Loudoun	10c. CITY, TOWN OR LOCATION Leesburg					10d. INSIDE CITY LIMITS? YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 202-1 Bldg. 8 Valley View Avenue, SW				10f. ZIP CODE 22075			10g. CITIZEN OF WHAT COUNTRY? U.S. of A.				
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Truck Driver		16b. KIND OF BUSINESS/INDUSTRY Town of Herndon, Virginia							
17. FATHER'S NAME (First, Middle, Last) Taylor William Gibson, Jr.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice McBride							
19e. INFORMANT'S NAME (Type/Print) Alice McBride (mother)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 28 - 4 Fort Evans Road, NE Leesburg, Va. 22075							
20e. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Union Cemetery			DATE 6/21	20c. LOCATION — City or Town, State Leesburg, Virginia					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Loudoun Funeral Chapel 158 Catoctin Circle, SE Leesburg, Va.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. c. d. DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):									Approximate interval Between Onset and Death months		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PSYCHIATRIC DISORDER (PARANOID SCHIZOPHRENIA)											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide				28e. DATE OF INJURY (Month, Day, Year) M	28b. TIME OF INJURY 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED				
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER D09867					29d. DATE SIGNED (Month, Day, Year) ► JUNE 18 1995		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RRR Roberts MD 15 W 7th St Frederick MD 21701-4599				31. REGISTRAR'S SIGNATURE 							
31. DATE FILED (Month, Day, Year) JUN 27 1995											

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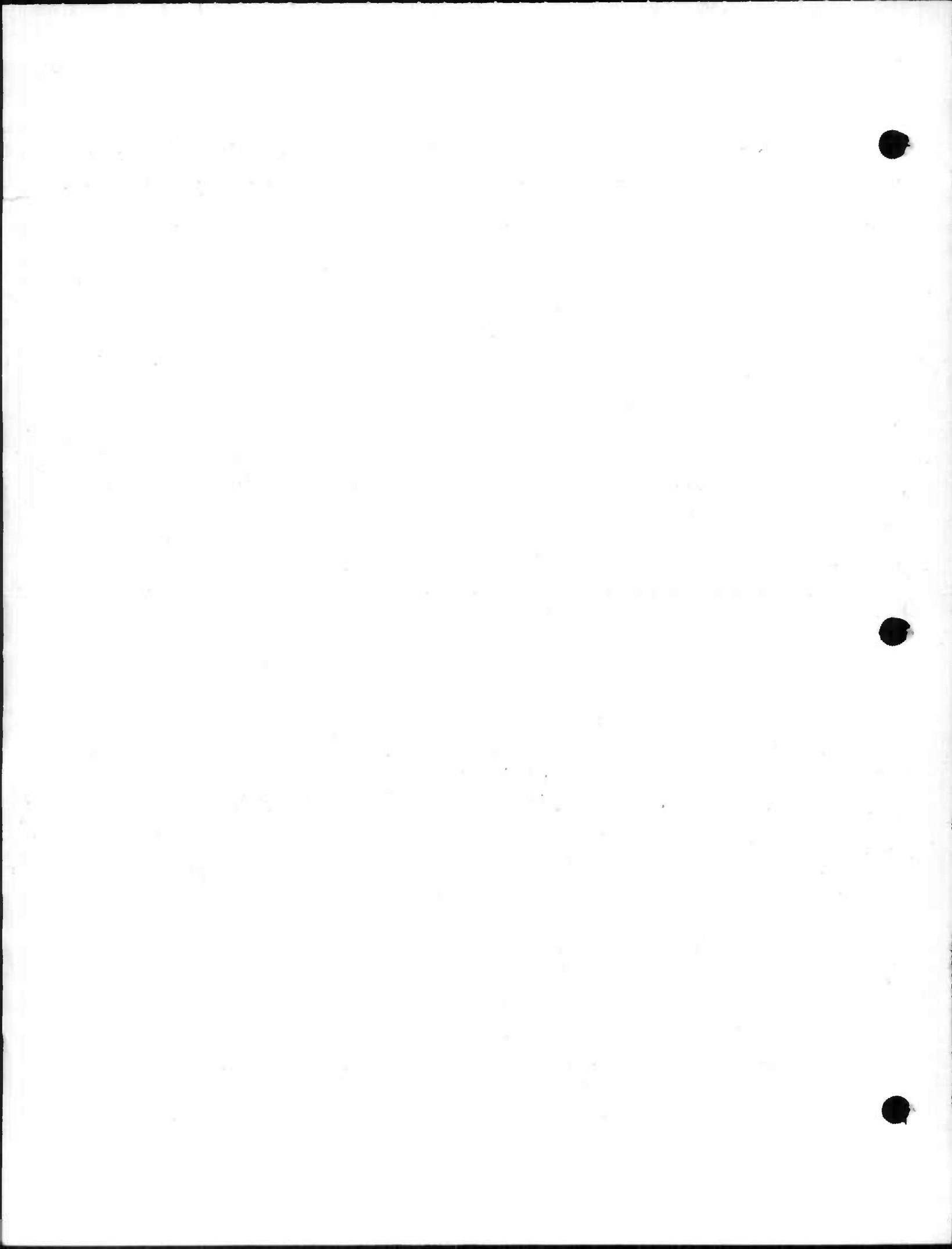
ITEMS: 23 PART I, 27, 28a-f, PER MEO FILM G-725 7/5/95 t.t.

95 19483

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

<p>TO BE COMPLETED BY FUNERAL DIRECTOR</p> <p>TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.</p> <p>TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.</p> <p>IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.</p>											
<p>STATE OF MARYLAND 21215-0020</p> <p>TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION</p>											
<p>1. DECEDENT'S NAME (First, Middle, Last)</p> <p>ROLAND GARNER JR.</p> <p>4. SOCIAL SECURITY NUMBER 579-64-2360</p> <p>5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p> <p>6. AGE (In yrs. last birthday) 47 YRS.</p> <p>IF UNDER 1 YEAR IF UNDER 24 HRS.</p> <p>MONTHS DAYS HOURS MIN.</p> <p>7. DATE OF BIRTH (Month, Day, Year) 8-31-47</p> <p>8. BIRTHPLACE (State or Foreign Country) WASH. D.C.</p>											
<p>9a. FACILITY NAME (If not institution, give street and number)</p> <p>PENN STATE SHOPPING CENTER</p> <p>9b. CITY, TOWN OR LOCATION OF DEATH Suitland Md.</p> <p>9c. COUNTY OF DEATH PRINCE GEORGES</p>											
<p>10a. STATE Md.</p> <p>10b. COUNTY P.G.</p> <p>10c. CITY, TOWN OR LOCATION Largo</p> <p>10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>											
<p>10e. STREET AND NUMBER 10115 Prince Pl. #402</p> <p>10f. ZIP CODE 20785</p> <p>10g. CITIZEN OF WHAT COUNTRY? U.S.A.</p>											
<p>11. MARITAL STATUS</p> <p><input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married</p> <p><input type="checkbox"/> Widowed <input type="checkbox"/> Divorced</p> <p>12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p> <p>If YES, GIVE WAR OR DATES</p> <p>13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)</p> <p><input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>Specify: Black</p> <p>14. RACE — American Indian, Black, White, etc.</p>											
<p>15. DECEDENT'S EDUCATION (Specify only highest grade completed)</p> <p>Elementary/Secondary (0-12) 12</p> <p>College (1-4 or 5+) </p> <p>16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Maintenance</p> <p>16b. KIND OF BUSINESS/INDUSTRY Private</p>											
<p>17. FATHER'S NAME (First, Middle, Last) Roland Garner</p> <p>18. MOTHER'S NAME (First, Middle, Maiden Surname) Elizabeth White</p>											
<p>19a. INFORMANT'S NAME (Type/Print) Elizabeth White</p> <p>19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9000 Briarcroft Lane #232 Laurel, Md. 20708</p>											
<p>20a. METHOD OF DISPOSITION</p> <p><input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State</p> <p><input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)</p> <p>20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)</p> <p>DATE</p> <p>20c. LOCATION — City or Town, State</p>											
<p>21. SIGNATURE OF FUNERAL SERVICE LICENSEE Janice Edwards</p> <p>22. NAME AND ADDRESS OF FACILITY Hodges & Edwards</p> <p>3910 Silver Hill Rd. Suitland Md.</p>											
<p>23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</p> <p>b. CONTACT GUNSHOT WOUNDS OF HEAD AND HAND</p> <p>DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Approximate Interval Between Onset and Death</p>											
<p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</p>											
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</p> <p>24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</p> <p><input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>											
<p>DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/></p>											
<p>25. WAS CASE REFERRED TO MEDICAL EXAMINER?</p> <p><input checked="" type="checkbox"/> YES <input type="checkbox"/> NO</p>		<p>26. PLACE OF DEATH (Check only one)</p> <p>HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA</p> <p>OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) IN VEHICLE</p>									
<p>27. MANNER OF DEATH</p> <p><input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation</p> <p><input type="checkbox"/> Accident <input type="checkbox"/> Unknown</p> <p><input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined</p> <p><input type="checkbox"/> Homicide</p>		<p>28a. DATE OF INJURY (Month, Day, Year) FOUND 5-19-95</p>		<p>28b. TIME OF INJURY UNKNOWN</p>		<p>28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO</p>		<p>28d. DESCRIBE HOW INJURY OCCURRED SELF-INFILCTED</p>			
<p>28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) (AUTO) SHOPPING CENTER</p>		<p>28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) PENNSYLVANIA AVE. & SILVER HILL RD., PRINCE GEORGE'S CO.</p>									
<p>29a. CERTIFIER</p> <p><input checked="" type="checkbox"/> C certifying physician</p> <p><input type="checkbox"/> MEDICAL EXAMINER</p>		<p>To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p> <p>On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</p>									
<p>30. SIGNATURE AND TITLE OF CERTIFIER J. Lauren Locker, MD</p>						<p>30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)</p> <p>111 Penn Street, Baltimore, Maryland 21201</p>		<p>30c. LICENSE NUMBER OCME</p> <p>30d. DATE SIGNED (Month, Day, Year) ► MAY 20, 1995</p>			
<p>31. DATE FILED (Month, Day, Year) JUN 29 1995</p>		<p>32. REGISTRAR'S SIGNATURE J. Lauren Locker</p>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

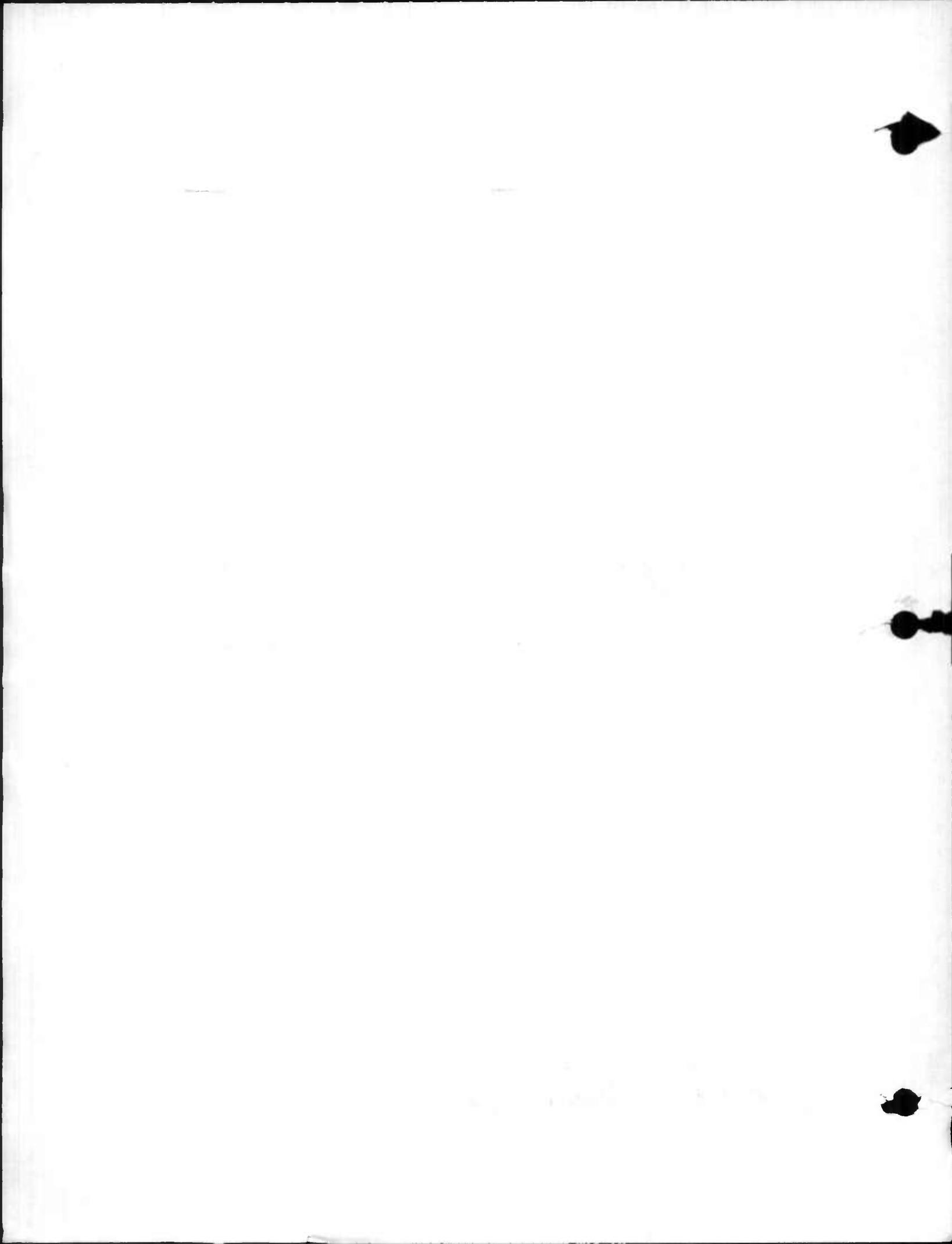
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO.		
1. DECEASED'S NAME (First, Middle, Last)									2. DATE OF DEATH	3. TIME OF DEATH	
John Fahey Gerryty									MONTH DAY YEAR	6:50 A M	
578-24-7729		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
578-24-7729		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	81 70 YRS.	MONTHS	DAYS	HOURS	MIN.	Month Day Year	April 19, 1917 Pennsylvania		
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH							9c. COUNTY OF DEATH		
10841 River Road		Denton							Caroline		
RESIDENCE OF DECEASED											
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION							10d. INSIDE CITY LIMITS?		
Maryland	Caroline	Denton							1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER	10f. ZIP CODE							10g. CITIZEN OF WHAT COUNTRY?			
10841 River Road	21629							U.S.A.			
11. MARITAL STATUS	12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II							13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEASED'S EDUCATION (Specify only highest grade completed)	16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)							16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 12	College (1-4 or 5+) 4 Journalist							Newspaper			
17. FATHER'S NAME (First, Middle, Last)	18. MOTHER'S NAME (First, Middle, Maiden Surname)										
Thomas Gerryty	Catherine Fahey										
19a. INFORMANT'S NAME (Type/Print)	19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)										
Evelyn T. Gerryty	10841 River Road, Denton, Maryland 21629										
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)	20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Crematorium							DATE	20c. LOCATION — City or Town, State		
<i>Ronald P. Moore</i>									6/1	Georgetown, Delaware	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald P. Moore</i>		22. NAME AND ADDRESS OF FACILITY Moore Funeral Home, P.A. PO Drawer B, Denton, Maryland 21629									
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Gastro Esophageal Reflux Disease</i> DUE TO (OR AS A CONSEQUENCE OF):										2 1/4	
b. _____ DUE TO (OR AS A CONSEQUENCE OF):											
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									29d. DATE SIGNED (Month, Day, Year) ► 6-1-95		
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen P. Carney</i>		29c. LICENSE NUMBER DO 1225									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
Stephen P. Carney, M.D., 509 Idlewild Avenue, Easton, Maryland 21601											
31. DATE FILED (Month, Day, Year) JUN 1 95		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pendleton</i>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

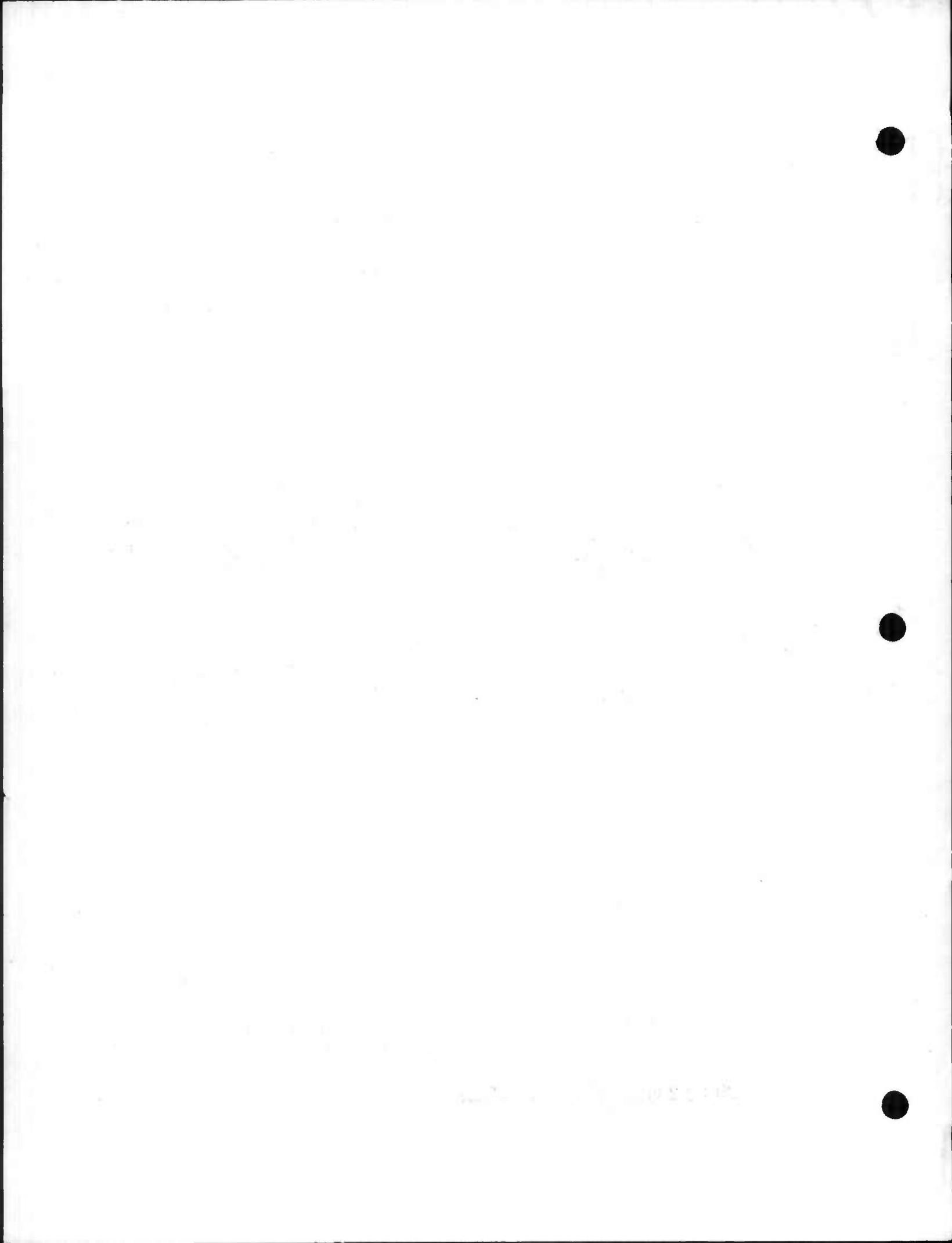
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19485

1. DECEASED'S NAME (First, Middle, Last)		Julio Ricky GONZALEZ				2. DATE OF DEATH MONTH 6	DAY 20	YEAR 95	3. TIME OF DEATH 1325 P.M.
4. SOCIAL SECURITY NUMBER		5. SEX 1 X M 2 F	6. AGE (In yrs. last birthday) 36 YRS.	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS. DAYS 0	IF UNDER 24 HRS. HOURS 0	IF UNDER 24 HRS. MIN. 0	7. DATE OF BIRTH (Month, Day, Year) July 31 1958	8. BIRTHPLACE (State or Foreign Country) N.Y. New York
9a. FACILITY NAME (If not institution, give street and number)		Washington County Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Hagerstown		9c. COUNTY OF DEATH Washington	
RESIDENCE OF DECEASED									
10a. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Hagerstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES X NO		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
10e. STREET AND NUMBER 17623 Homewood Road						10f. ZIP CODE 21740	10g. CITIZEN OF WHAT COUNTRY? U.S.A.		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 X Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 X YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1979-1992	13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X YES 2 <input type="checkbox"/> NO Specify: Puerto Rican				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12	16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) 2 Radio Technician	16b. KIND OF BUSINESS/INDUSTRY Military							
17. FATHER'S NAME (First, Middle, Last) Julio Gonzalez		18. MOTHER'S NAME (First, Middle, Maiden Surname) Vincenta Rosario							
19a. INFORMANT'S NAME (Type/Print) Marta L. Gonzalez		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 17623 Homewood Road Hagerstown, Maryland 21740							
20a. METHOD OF DISPOSITION 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place), Arlington National Cemetery 6-28-95 Arlington, Virginia				OATE	20c. LOCATION — City or Town, State 6-28-95 Arlington, Virginia		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James L. Spier		22. NAME AND ADDRESS OF FACILITY Minnich Funeral Home 415 E. Wilson Blvd. Hagerstown, Md. 21740							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic Pulmonary Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Sarcoid Immune Deficiency Syndrome</i> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death Minutes Months Years									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 X NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Marta L. Galloway		29c. LICENSE NUMBER D31880				29d. DATE SIGNED (Month, Day, Year) 6/21/95			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Marta L. Galloway, RN, LPN Medical Campus Rd Hagerstown, MD									
31. DATE FILED (Month, Day, Year) JUN 22 1995		32. REGISTRAR'S SIGNATURE Jahira Shuler-Randall							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

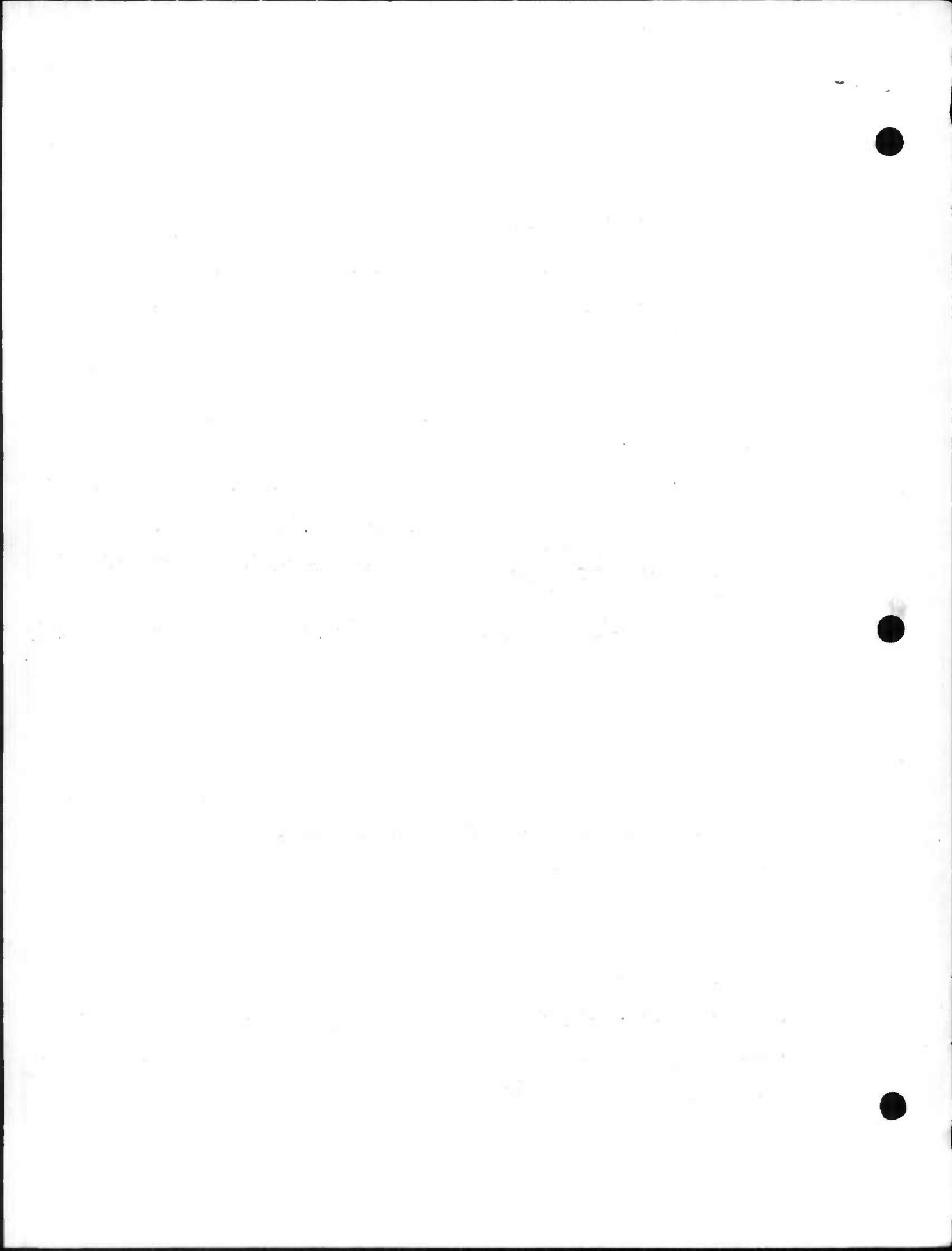
1 - FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19486

1. DECEASED'S NAME (First, Middle, Last) Robert Celland Grosh						2. DATE OF DEATH MONTH June DAY 17 , YEAR 1995	3. TIME OF DEATH 6:23 A M
4. SOCIAL SECURITY NUMBER 279-52-3718		5. SEX 1 X M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0	7. DATE OF BIRTH (Month, Day, Year) Sept. 12, 1951	
9e. FACILITY NAME (If not institution, give street and number) Frederick Memorial Hospital						9b. CITY, TOWN OR LOCATION OF DEATH Frederick	
9c. COUNTY OF DEATH Fredick						8. BIRTHPLACE (State or Foreign Country) Ohio	
10e. STATE Ohio		10b. COUNTY Franklin Co.		10c. CITY, TOWN OR LOCATION Columbus,			10d. INSIDE CITY LIMITS? 1 X YES 2 <input type="checkbox"/> NO
10e. STREET AND NUMBER 1658 West 3rd Avenue						10f. ZIP CODE 43212	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 X NO IF YES, GIVE WAR OR DATES X			13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 X NO Specify: White		
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+)			16b. KIND OF BUSINESS/INDUSTRY 2 Furniture Refinisher Furniture Refinishing		
17. FATHER'S NAME (First, Middle, Last) Robert Filmore Grosh						18. MOTHER'S NAME (First, Middle, Maiden Surname) Viva Geraldine Clelland	
19e. INFORMANT'S NAME (Type/Print) Robert Grosh						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1707 ? Cardiff Rd. Columbus, Ohio. 43221	
20e. METHOD OF DISPOSITION 1 X Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Green Lawn Cemetery			DATE 6/20/95	20c. LOCATION — City or Town, State Columbus, Ohio	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE M00849 <i>Paul T. Lochstampfor</i>						22. NAME AND ADDRESS OF FACILITY Snyder-Lochstampfor F.H. Inc. 48 South Church St., Waynesboro, Pa. 17268	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.						Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE						months	
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 X NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 X YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 X Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Other 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY	28c. INJURY AT WORK? M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29e. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Robert R.R. Roberts MD						29c. LICENSE NUMBER D07867	29d. DATE SIGNED (Month, Day, Year) ► 06/17/95
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) RRR Roberts MD, 515 W 7th St Frederick MD 21701 - 4599							
31. DATE FILED (Month, Day, Year) JUN 1 1995		32. REGISTRAR'S SIGNATURE <i>Linda</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

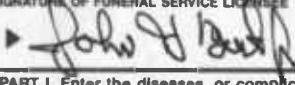
D TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

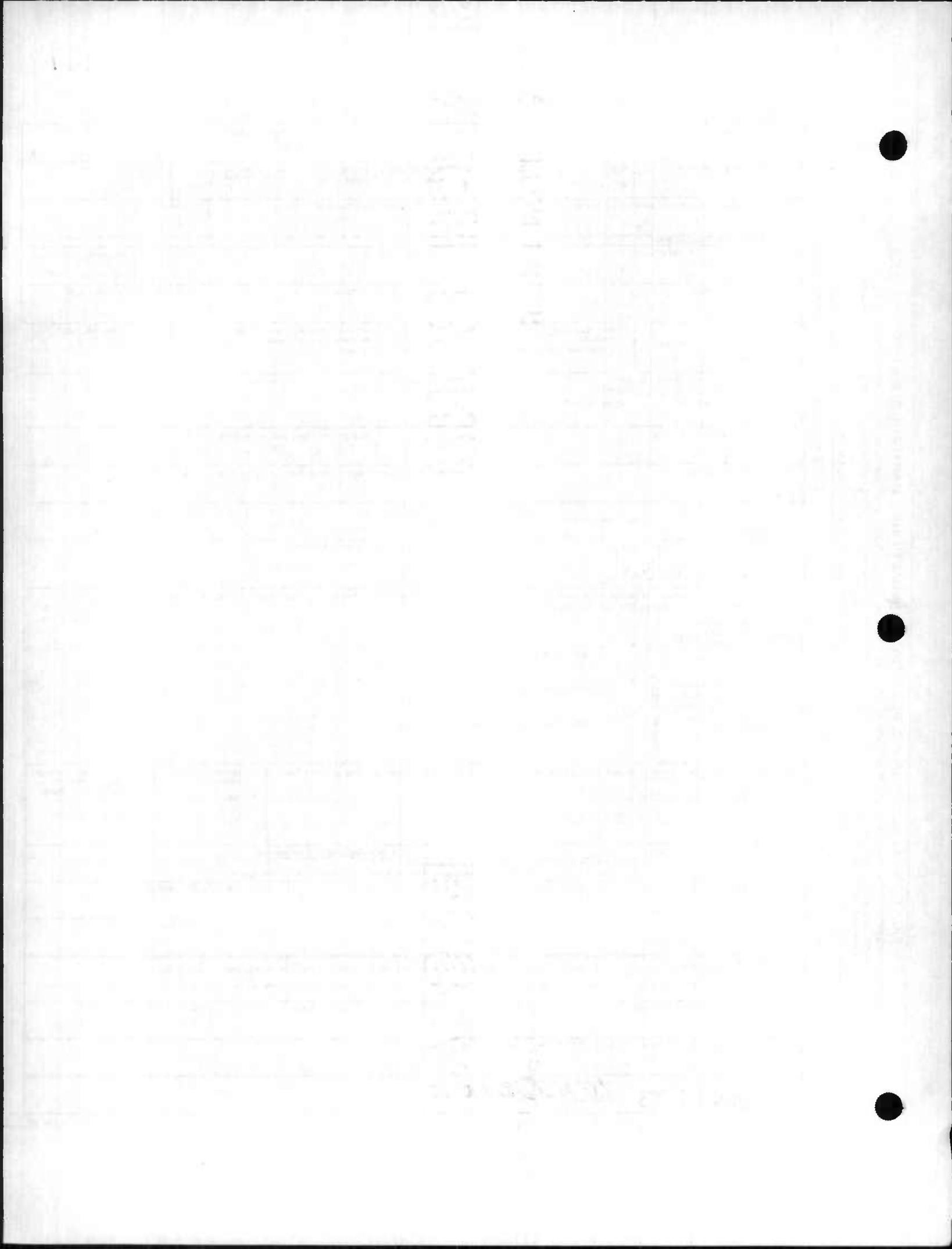
TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19487

1. DECEDENT'S NAME (First, Middle, Last) Lloyd Gross				2. DATE OF DEATH MONTH DAY YEAR June 15 1995	3. TIME OF DEATH 1:57 PM		
4. SOCIAL SECURITY NUMBER 212-03-7999		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 101 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 0 0 0 0	7. DATE OF BIRTH (Month, Day, Year) Sept. 15, 1893	8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Reeder Memorial Home				9b. CITY, TOWN OR LOCATION OF DEATH Boonsboro		9c. COUNTY OF DEATH Washington	
10a. STATE Maryland		10b. COUNTY Washington		10c. CITY, TOWN OR LOCATION Boonsboro		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 416 N. Main St.				10f. ZIP CODE 21713		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter		16b. KIND OF BUSINESS/INDUSTRY Home Improvement			
17. FATHER'S NAME (First, Middle, Last) John T. Gross				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Deener			
19a. INFORMANT'S NAME (Type/Print) J. Wesley Deavers				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 411 N. Main St., Boonsboro, Md. 21713			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Boonsboro Cemetery		DATE 6-17-95	20c. LOCATION — City or Town, State Boonsboro, Md. 21713		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY BAST FUNERAL HOME, 7606 Old National Pike Boonsboro, Md. 21713			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		Approximate Interval Between Onset and Death days					
s. <i>Pneumonia</i>							
b. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>							
c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>							
d. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anterior stroke</i> <i>Cardiovascular disease</i> <i>Carboxygenous accident</i>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Vasant Datta</i>		29c. LICENSE NUMBER D18019		29d. DATE SIGNED (Month, Day, Year) ► June 16, 1995			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Vasant Datta, 334 Mill Street, Hagerstown MD. 21740							
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE <i>John Deaver-Bast</i>					



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

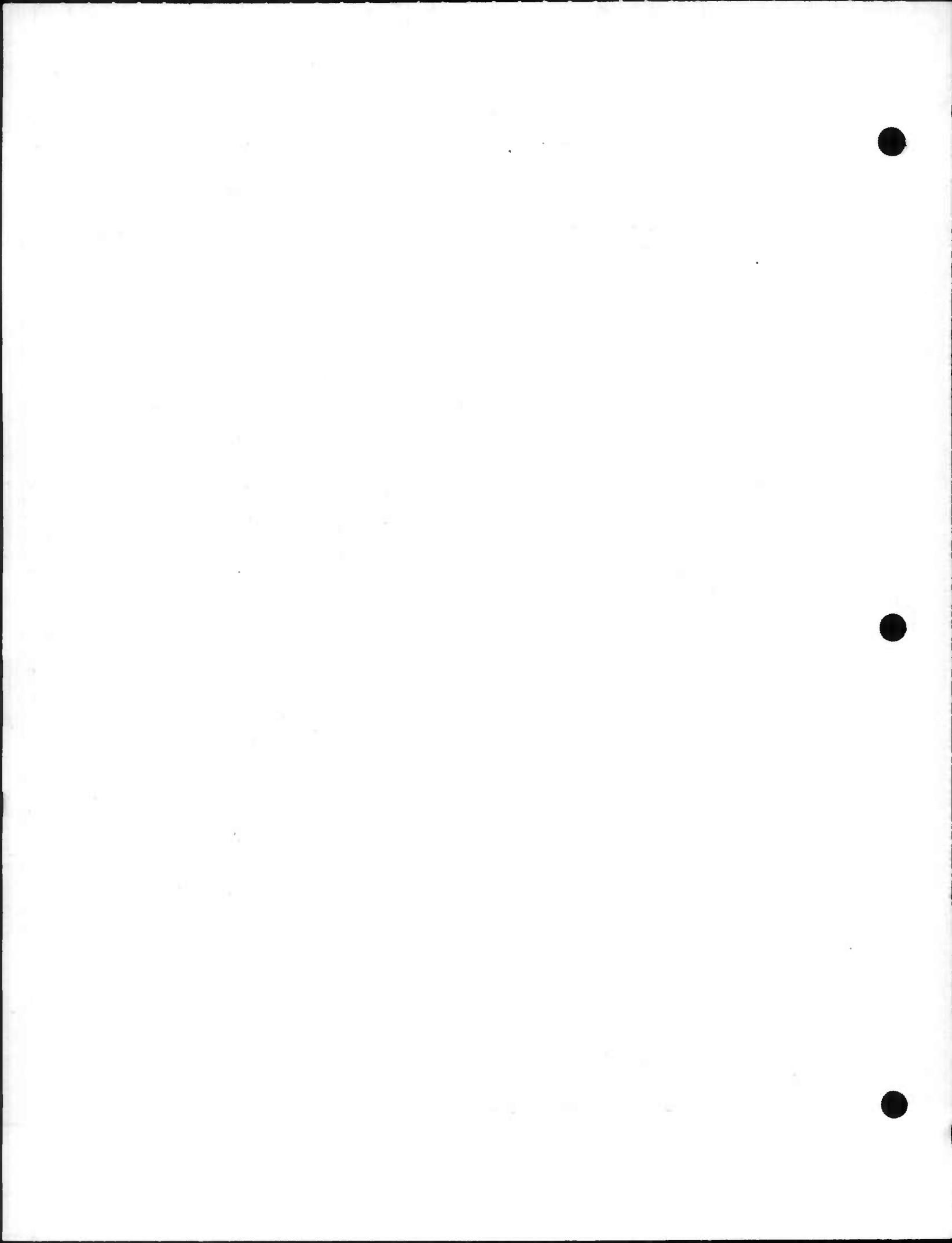
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)															
Carole J. Gray															
4. SOCIAL SECURITY NUMBER			5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH		
214-56-0841			1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		45 YRS.		MONTHS DAYS		HOURS MIN.		June 04 1995		1:00 AM		
9a. FACILITY NAME (If not institution, give street and number)			9b. CITY, TOWN OR LOCATION OF DEATH												9c. COUNTY OF DEATH
Fairfield Nursing Center			Crownsville												Anne Arundel
RESIDENCE OF DECEDENT															
10a. STATE MD.	10b. COUNTY ANNE ARUNDEL	10c. CITY, TOWN OR LOCATION ANNAPOLIS											10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER 1908 F. COPELAND STREET				10f. ZIP CODE 21401				10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: BLACK						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) FOOD SERVICE WORKER			16b. KIND OF BUSINESS/INDUSTRY U.S. NAVAL ACADEMY									
17. FATHER'S NAME (First, Middle, Last) ABRAHAM DORSEY						18. MOTHER'S NAME (First, Middle, Maiden Surname) JOSEPHINE FRANKLIN									
19a. INFORMANT'S NAME (Type/Print) FLORENCE CAVINESS						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1908 F. COPELAND ST. ANNAPOLIS, MD. 214401									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery, or other place) CHEWS CHURCH CEMETERY 6/8/95						DATE	20c. LOCATION — City or Town, State OWENSVILLE, MD.		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry G. Reese</i>						22. NAME AND ADDRESS OF FACILITY REESE & SONS MORTUARY, P.A. 821 WEST ST. ANNAPOLIS, MD. 21401									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.													Approximate Interval Between Onset and Death 16-15 yrs		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Huntington's chorea</i>															
b. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>															
c. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>															
d. <i>DUE TO (OR AS A CONSEQUENCE OF):</i>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTIMER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)												
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M			28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED				
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING-PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Carole J. Gray, MD</i>			29c. LICENSE NUMBER Q-19528			29d. DATE SIGNED (Month, Day, Year) ► <i>6/19/95</i>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5411 Old Frederick Rd. Balto. Md.			31. DATE FILED (Month, Day, Year) JUN 15 1995			32. REGISTRAR'S SIGNATURE <i>J. Smith, Registrar</i>									



DIVISION OF VITAL RECORDS, P.O. BOX 68760

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

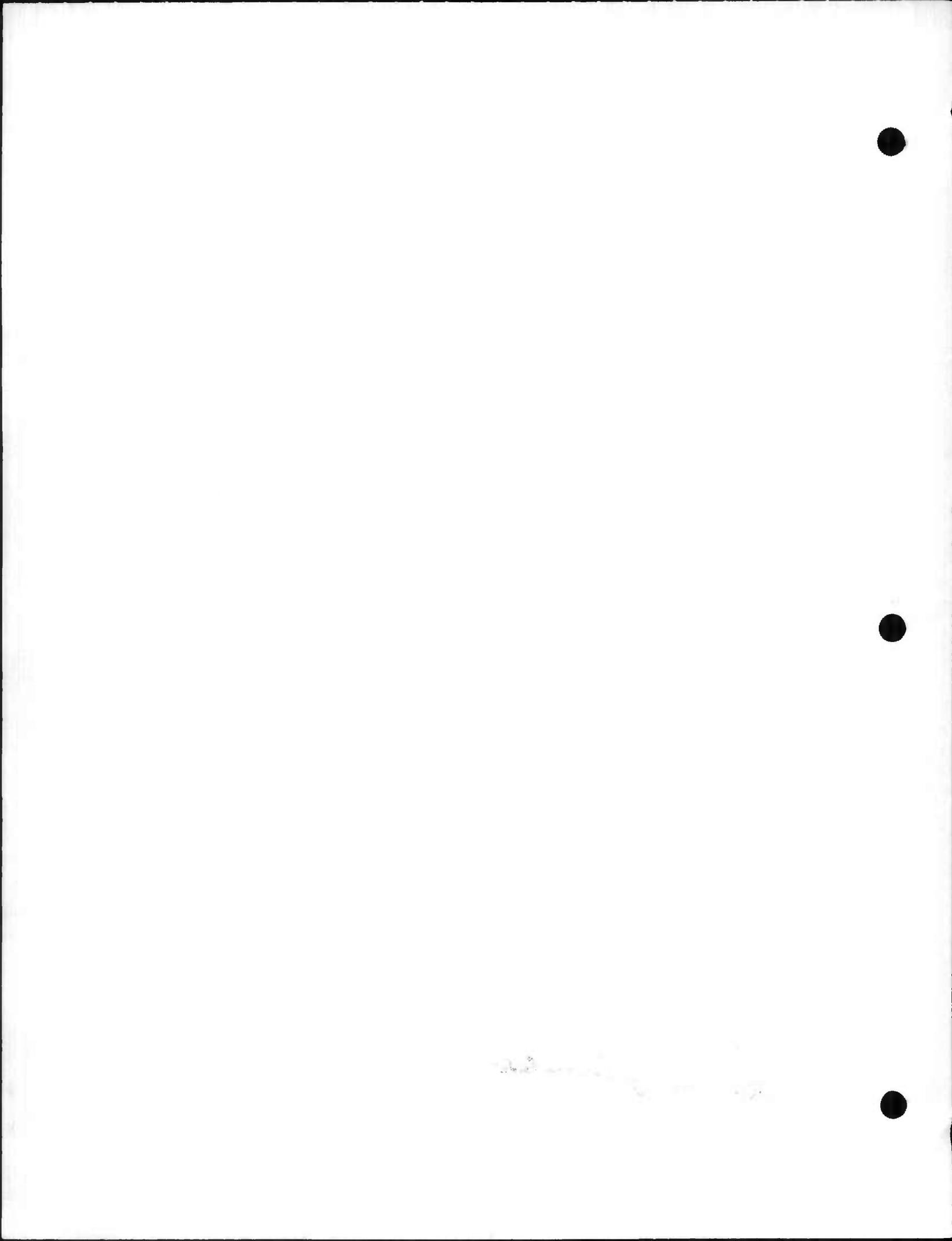
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) Mary Ethel GOVER												2. DATE OF DEATH MONTH DAY YEAR June 5, 1995	3. TIME OF DEATH 6:00 p m
4. SOCIAL SECURITY NUMBER 216-16-4190			5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 74 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) Dec. 17, 1920			8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 11035 Hickory School Road			9b. CITY, TOWN OR LOCATION OF DEATH Williamsport			9c. COUNTY OF DEATH Washington							
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STATE Maryland	10b. COUNTY Washington	10c. CITY, TOWN OR LOCATION Williamsport			10f. ZIP CODE 21740			10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: white				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) management			16b. KIND OF BUSINESS/INDUSTRY banking							
17. FATHER'S NAME (First, Middle, Last) William Augustus Gover						18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Elizabeth Bitner							
19a. INFORMANT'S NAME (Type/Print) Clara Maples			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Route 1, Box 3475, Havana, F1. 32333			20c. LOCATION — City or Town, State Montgomery Co., Md.							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Hyattstown Methodist Cem. 6-9-95			DATE							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			22. NAME AND ADDRESS OF FACILITY MINNICH FUNERAL HOME 415 E. Wilson Blvd., Hagerstown, Md. 21740										
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death sudden	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary occlusion DUE TO (OR AS A CONSEQUENCE OF):													
b. Atherosclerotic heart disease DUE TO (OR AS A CONSEQUENCE OF):												years	
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH X <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide			26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> ND		28d. DESCRIBE HOW INJURY OCCURRED				
			28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 			29c. LICENSE NUMBER D11266			29d. DATE SIGNED (Month, Day, Year) June 6, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Howard N. Weeks, M.D., 580 Northern Avenue, Hagerstown, Maryland 21742													
31. DATE FILED (Month, Day, Year) June 1995			32. REGISTRAR'S SIGNATURE 										



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

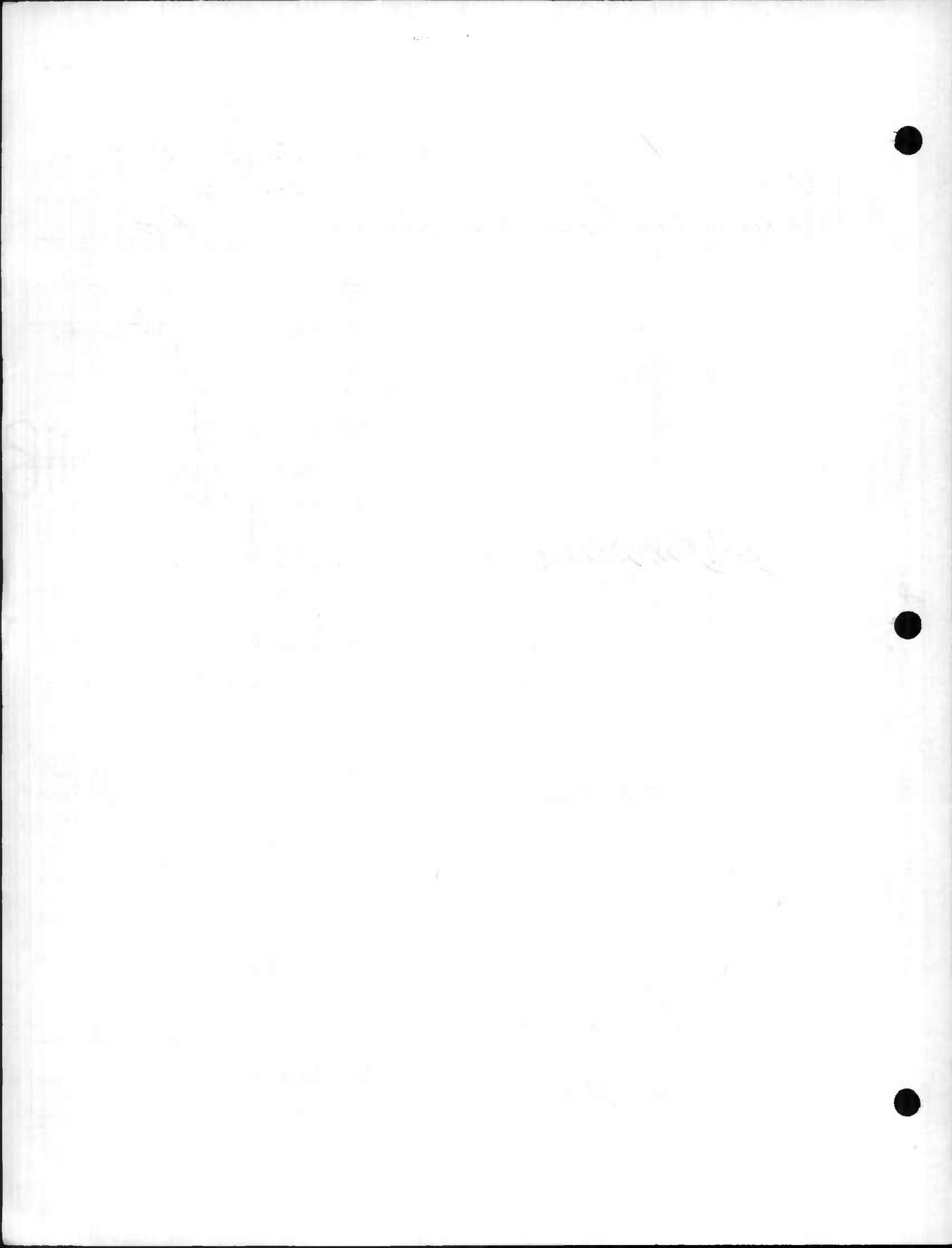
1. FOR
STATE
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

95 19490

1. DECEDENT'S NAME (First, Middle, Last)		PEARL W. Grimes				2. DATE OF DEATH	June 12, 1995	TIME OF DEATH
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	7. DATE OF BIRTH	06-12-95	MONTH DAY YEAR
212-88-1348		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	98 YRS.	MONTHS	DAYS	Month, Day, Year	09-10-96	40610
9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH				8. BIRTHPLACE (State or Foreign Country)		
Pinetree Nursing & Rehab Center Clinton		Clinton				Maryland		
RESIDENCE OF DECEDENT								
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?		
Md.	Prince George	Brandywine				<input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER		10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?		
16211 Ash Box Road		20613				USA		
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced								
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY		
Elementary/Secondary (0-12) 8 grades		College (1-4 or 5+) - 0 - Homemaker				Domestic		
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)						
Leonard Perry Cage		EMily Walton McKinturff						
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)						
Rev. O. Walton Grimes		16209 Ash Box Rd., Brandywine, Md. 20613						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of Cemetery, crematory or other place) Cedarville Church Cemetery				DATE	20c. LOCATION — City or Town, State	
Benjamin M. Matthews M00658						6/15	Cedarville, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSER <i>Benjamin M. Matthews</i>								
22. NAME AND ADDRESS OF FACILITY The Hunt Funeral Home, Inc. P.O. Box 156, Waldorf, Md. 20604								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								
<p>a. <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>b. <i>Arteriosclerotic heart disease</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c. <i>Hypertension</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d. <i></i></p>								
Approximate Interval Between Onset and Death Days								
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
<p>24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p> <p>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</p>								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 3 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED		
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>HYO K. Lee, M.D.</i>		29c. LICENSE NUMBER D 15595				29d. DATE SIGNED (Month, Day, Year) ► 06/13/95		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)								
HYO K. Lee, M.D. 11610 Forest Glen Dr Mitchellville, MD 20721								
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE <i>Jane Weller-Hendall</i>						



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

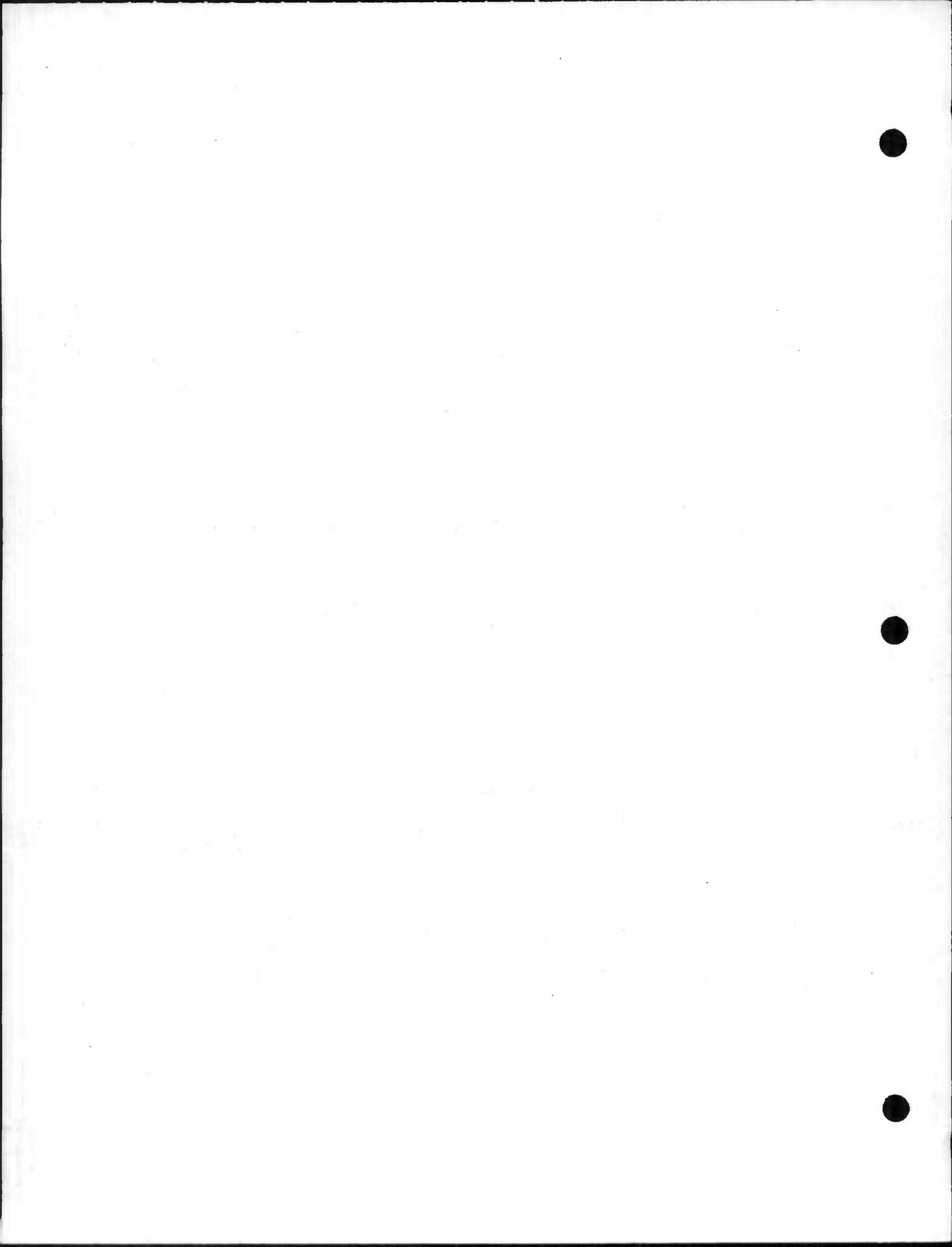
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

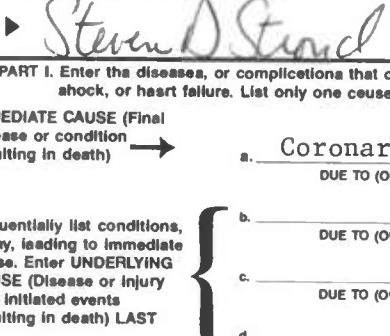
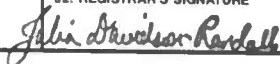
TO BE COMPLETED BY FUNERAL DIRECTOR

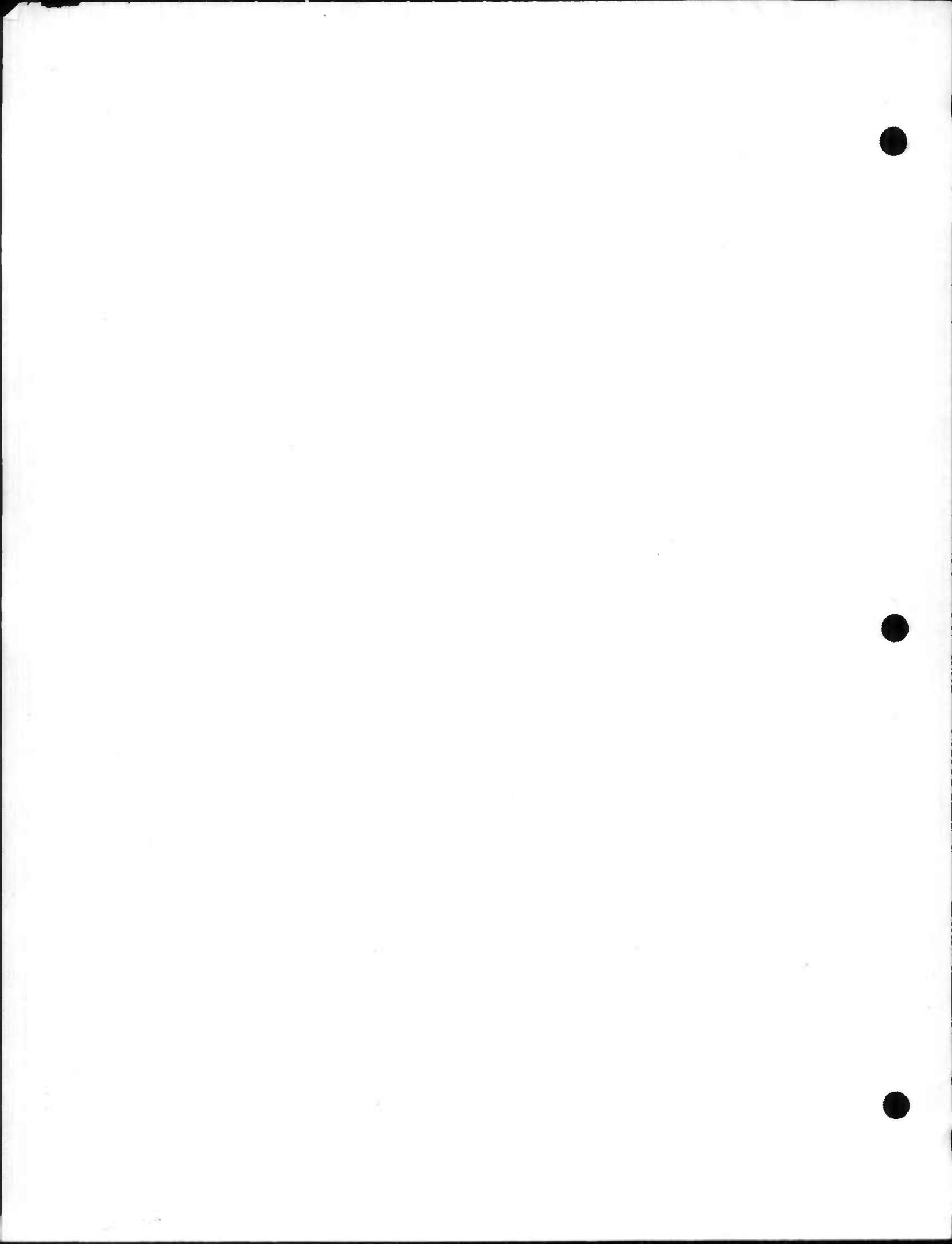
1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH							REG. NO. 95 19491				
1. DECEDENT'S NAME (First, Middle, Last) William M. Gregory							2. DATE OF DEATH MONTH June DAY 11 YEAR 1995		3. TIME OF DEATH P.M. 6:00				
4. SOCIAL SECURITY NUMBER 577-22-6480		5. SEX M	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Nov. 26, 1913		8. BIRTHPLACE (State or Foreign Country) West Virginia			
9a. FACILITY NAME (If not institution, give street and number) 1003 Lanark Way							9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery				
RESIDENCE OF DECEDENT													
10a. STATE Maryland	10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? NO								
10e. STREET AND NUMBER 1003 Lanark Way			10f. ZIP CODE 20901			10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS Never Married		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? YES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) NO			14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman			16b. KIND OF BUSINESS/INDUSTRY Furniture								
17. FATHER'S NAME (First, Middle, Last) Mathers Gregory		18. MOTHER'S NAME (First, Middle, Maiden Surname) Charles Wesley Gregory			19. SUSPENDED 19a. INFORMANT'S NAME (Type/Print) Susanne G. Farmer								
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 550 Mt. Harmony Rd. Owings, MD 20736		20a. METHOD OF DISPOSITION Burial						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery		DATE 6/14/95	20c. LOCATION — City or Town, State Brentwood, Maryland		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Ramsey		22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home Inc.						23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST					
A. Hypertension Failure B. Chronic obstructive Lung Disease C. Coronary Lung Circumference										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES NO UNCERTAIN													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? NO		26. PLACE OF DEATH (Check only one) HOSPITAL: Inpatient		27. MANNER OF DEATH Natural		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? NO		28d. DESCRIBE HOW INJURY OCCURRED	
27. MANNER OF DEATH Natural		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK? NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number; City or Town, State)											
29a. CERTIFIER (Check only one) CERTIFYING PHYSICIAN : To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Carroll D. Mahaney M.D.		29c. LICENSE NUMBER 014777		29d. DATE SIGNED (Month, Day, Year) 6-12-91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Carroll D. Mahaney 1030 Georgia Ave. Silver Spring Md 20902		31. DATE FILED (Month, Day, Year) JUN 15 1995		32. REGISTRAR'S SIGNATURE John Davidor Kardell		33. DHMH-16 Rev 1/89							



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**TO BE COMPLETED BY FUNERAL DIRECTOR**

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1 - STATE REGISTRAR		2. DATE OF DEATH MONTH DAY YEAR June 12 1995								3. TIME OF DEATH 9:00 AM	
1. DECEDENT'S NAME (First, Middle, Last) Bernice Johnson Goodyear										7. DATE OF BIRTH (Month, Day, Year) June 20, 1905	
4. SOCIAL SECURITY NUMBER 579-44-2592		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 89 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MINN.	8. BIRTHPLACE (State or Foreign Country) Utah					
9a. FACILITY NAME (If not institution, give street and number) Mariner of Greater Laurel										9b. CITY, TOWN OR LOCATION OF DEATH Laurel	
9c. COUNTY OF DEATH Prince Georges											
RESIDENCE OF DECEDENT											
10a. STATE Maryland	10b. COUNTY Prince Georges	10c. CITY, TOWN OR LOCATION Bowie								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4105 Woodhaven Lane										10f. ZIP CODE 20715	10g. CITIZEN OF WHAT COUNTRY? USA
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home					
17. FATHER'S NAME (First, Middle, Last) Jacob Carl Johnson, Jr.										18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Kelsey	
19a. INFORMANT'S NAME (Type/Print) Maxine Frances McDermond										19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4105 Woodhaven Lane Bowie, Maryland 20715	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gate of Heaven Cemetery				DATE 6/16/95	20c. LOCATION — City or Town, State Silver Spring, Maryland				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 										22. NAME AND ADDRESS OF FACILITY Francis J. Collins Funeral Home, Inc. 500 University Blvd.W. Sil.Spr. MD 20901	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate Interval Between Onset and Death Years	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Coronary Artery Disease DUE TO (OR AS A CONSEQUENCE OF):											
b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Depression, Major Organic brain syndrome										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA 4 <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D42767								29d. DATE SIGNED (Month, Day, Year) ► June 12, 1995	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Chris Manik, M.D. 8317 Cherry Lane Laurel, Maryland 20707										31. DATE FILED (Month, Day, Year) JUN 14 1995	
32. REGISTRAR'S SIGNATURE 											

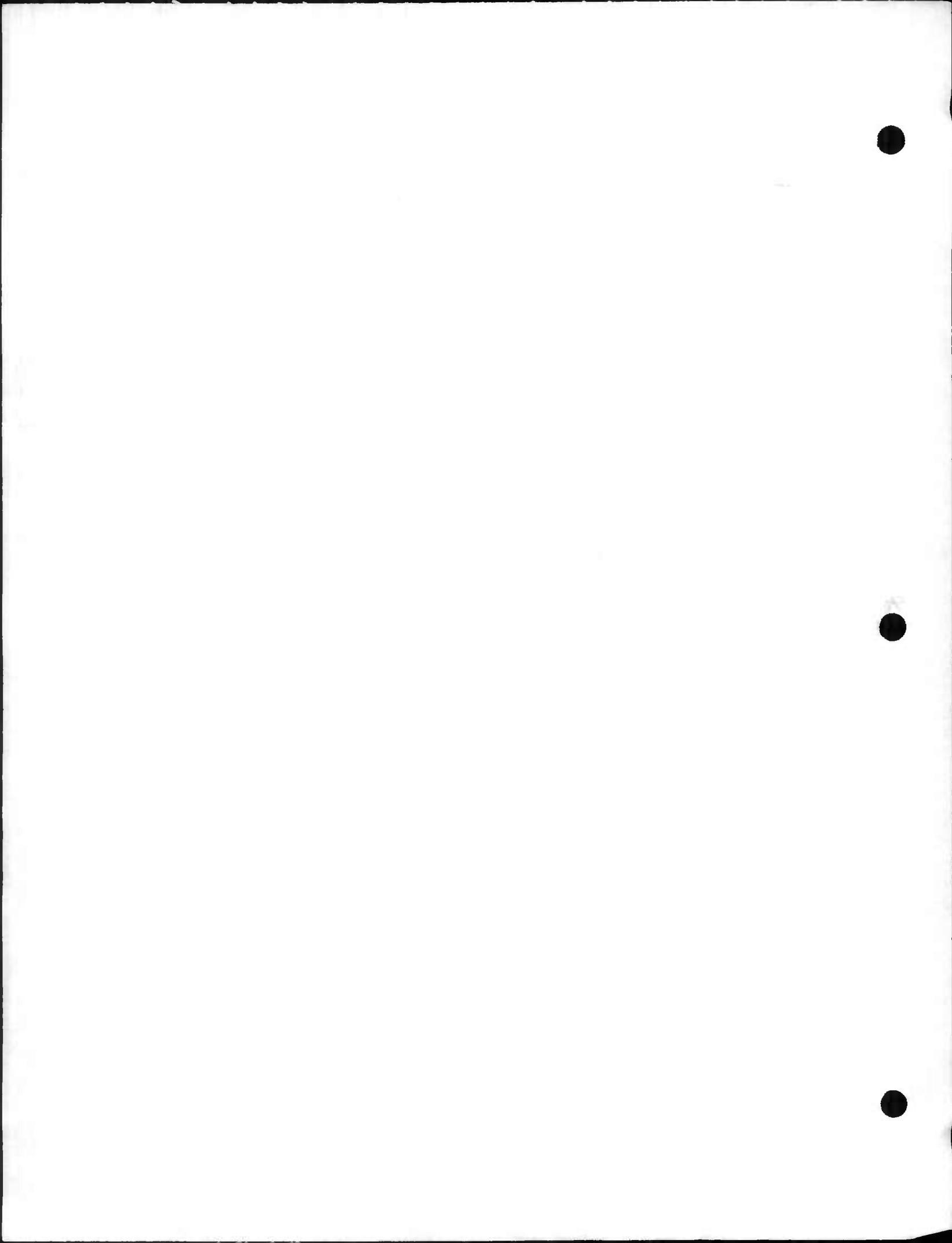


95 19493

FOR
STATE
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Elizabeth Furey Grant												2. DATE OF DEATH MONTH DAY YEAR June 8, 1995	3. TIME OF DEATH 9:55 AM
4. SOCIAL SECURITY NUMBER 467-34-6662		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 79 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) Dec. 27, 1915		8. BIRTHPLACE (State or Foreign Country) Connecticut					
9a. FACILITY NAME (If not institution, give street and number) Wilson Health Care Center				9b. CITY, TOWN OR LOCATION OF DEATH Gaithersburg				9c. COUNTY OF DEATH Montgomery					
RESIDENCE OF DECEDENT												10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE Maryland	10b. COUNTY Montgomery	10c. CITY, TOWN OR LOCATION Gaithersburg				101. ZIP CODE 20877		10g. CITIZEN OF WHAT COUNTRY? United States					
10e. STREET AND NUMBER 301 Russell Avenue													
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Secretary				16b. KIND OF BUSINESS/INDUSTRY Government							
17. FATHER'S NAME (First, Middle, Last) William Furey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ida Cramer									
19a. INFORMANT'S NAME (Type/Print) Carol C. Culp				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 503 South College Street, Carlisle, Pennsylvania 17013									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glenwood Cemetery June 12, 1995				DATE		20c. LOCATION — City or Town, State Washington, DC					
21. SIGNATURE OF FUNERAL SERVICE LICENSE Barbara Jo McMullan Lawrence		MO0831		22. NAME AND ADDRESS OF FACILITY Robert A. Pumphrey Funeral Home/ Rockville, Inc. 300 West Montgomery Avenue, Rockville, Maryland 20850-2805									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →													
a. Sepsis DUE TO (OR AS A CONSEQUENCE OF):													
b. Insulin-dependent diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF):													
c. DUE TO (OR AS A CONSEQUENCE OF):													
d. DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Atrial Fibrillation												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Undetermined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER John P. Musher, M.D.		29c. LICENSE NUMBER D33357				29d. DATE SIGNED (Month, Day, Year) ► June 8, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Jonathan Musher, M.D., 6320 Democracy Blvd., Bethesda, Maryland 20817													
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE Julia Davidson Randall											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

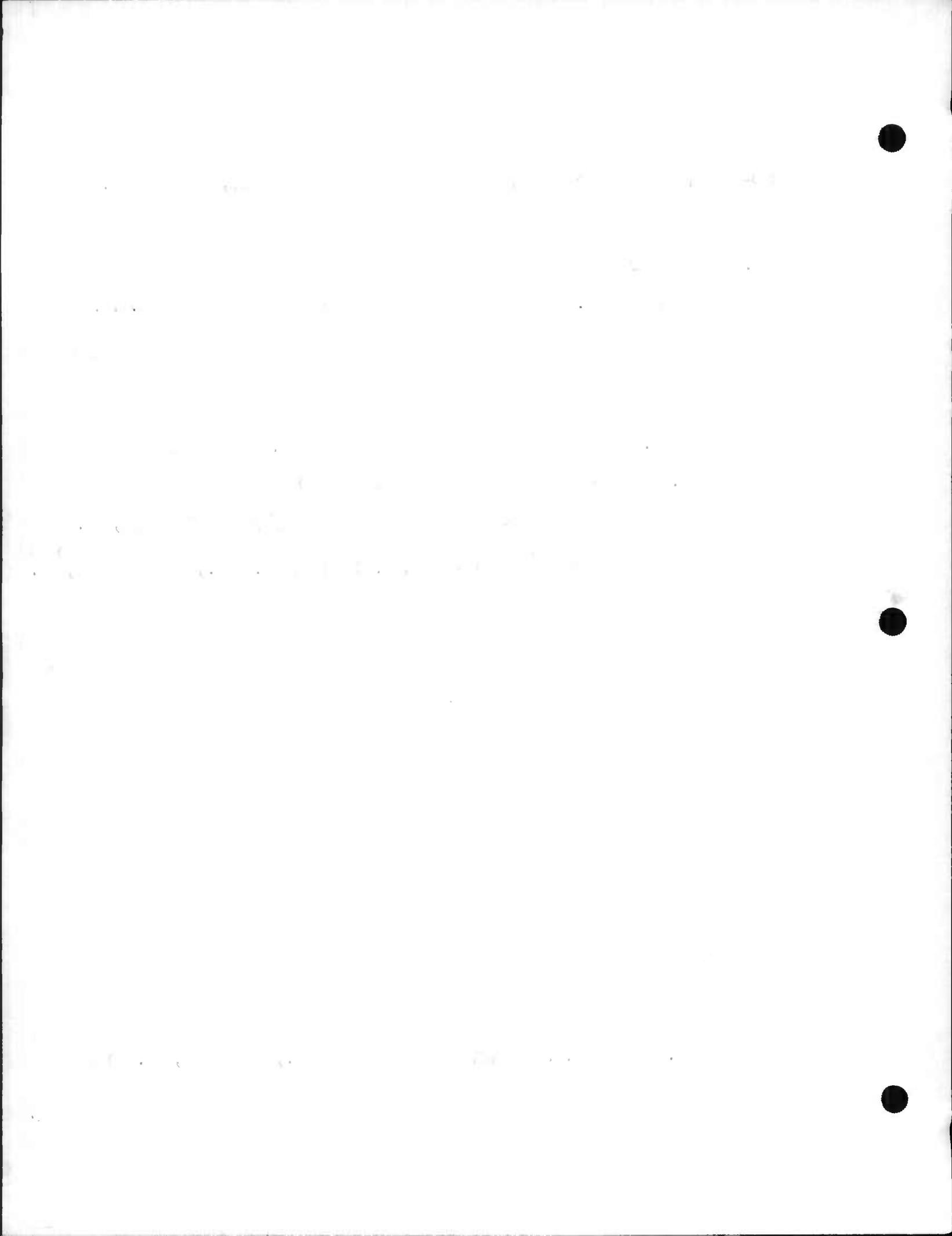
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED'S NAME (First, Middle, Last)											2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH	
June A. GLASGOW											June 11 1995	9:15 PM	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
060-16-8174		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		76 YRS.		MONTHS DAYS		HOURS MIN.					
9a. FACILITY NAME (If not institution, give street and number)											7. DATE OF BIRTH (Month, Day, Year)		
SHADY GROVE NURSING/REHAB CENTER											MAY 17, 1919		
RESIDENCE OF DECEASED											8. BIRTHPLACE (State or Foreign Country)		
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?							
MD.		MONTGOMERY		POTOMAC		<input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?							
9012 BRICKYARD RD.				20854		U.S.A.							
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISpanic ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify:							
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced						WHITE							
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY									
Elementary/Secondary (0-12) 12		College (1-4 or 5+)		HOUSEWIFE		AT HOME							
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)											
EARLE S. ROWE		E. HARRIS											
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
NORMAN M. GLASGOW		SAME AS ITEM #10											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, cemetery or other place) CHAMBERS CREMATORY		DATE 6/13		20c. LOCATION — City or Town, State RIVERDALE, MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>W.W. Chambers</i>		22. NAME AND ADDRESS OF FACILITY M00091 W. W. CHAMBERS CO. INC., SILVER SPRING, MD.		20910									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →										MINS.			
a. Cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF):													
b. Metastatic endometrial carcinoma DUE TO (OR AS A CONSEQUENCE OF):										YRS.			
c. _____ DUE TO (OR AS A CONSEQUENCE OF):													
d. _____ DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)		OTHER: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>George A. Sotos</i>		29c. LICENSE NUMBER D43083		29d. DATE SIGNED (Month, Day, Year) ► 6/12/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		GEORGE A. SOTOS M.D.		9707 MEDICAL CENTER DR., ROCKVILLE, MD. 20852									
31. DATE FILED (Month, Day, Year) JUN 13 1995		32. REGISTRAR'S SIGNATURE <i>Jeanne Dawson Harrell</i>											

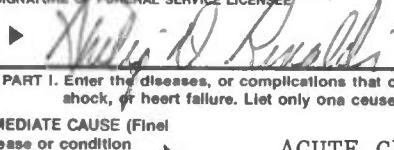
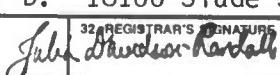


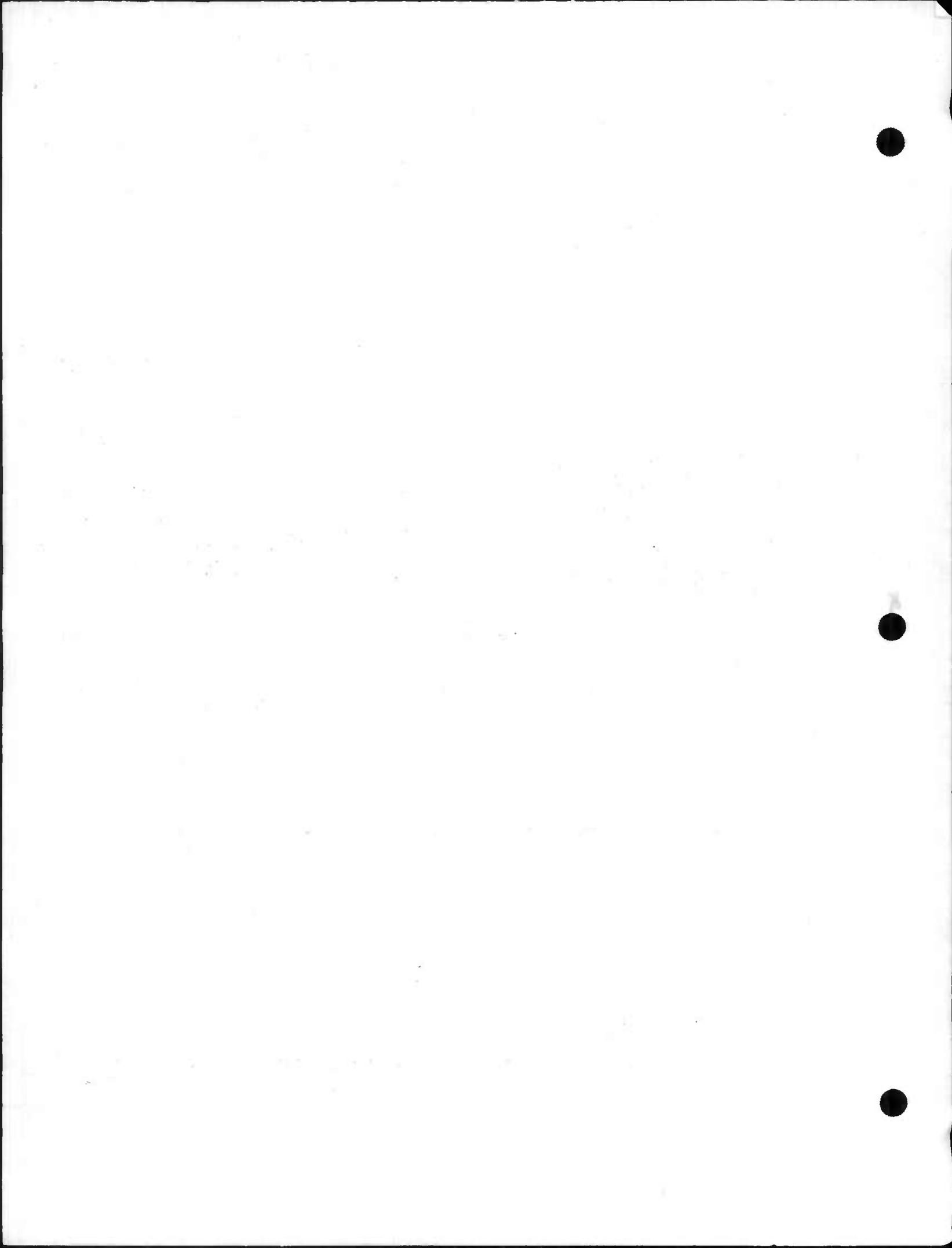
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEASED'S NAME (First, Middle, Last) HELEN GALICH										2. DATE OF DEATH MONTH DAY YEAR JUNE 14, 1995	3. TIME OF DEATH A.M.	
4. SOCIAL SECURITY NUMBER 209-24-1384A		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 86 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	7. DATE OF BIRTH (Month, Day, Year) Sept. 20, 1908		8. BIRTHPLACE (State or Foreign Country) Pennsylvania				
9a. FACILITY NAME (If not institution, give street and number) Brook Grove Nursing Home					9b. CITY, TOWN OR LOCATION OF DEATH Sandy Springs			9c. COUNTY OF DEATH Montgomery				
10e. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Sandy Springs			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 18430 Brook Grove Road					10f. ZIP CODE 20860			10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF NISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: White			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 3			16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker			16b. KIND OF BUSINESS/INDUSTRY Own Home						
17. FATHER'S NAME (First, Middle, Last) Peter Salaski					18. MOTHER'S NAME (First, Middle, Maiden Surname) Unobtainable							
19e. INFORMANT'S NAME (Type/Print) Mildred G. Radovich					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 913 Hillside Lake Terr., #411, Gaithersburg, MD 20878							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)					20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) St. George Serbian Orth. Cem.			DATE 6/17	20c. LOCATION — City or Town, State Carmichaels, Pennsylvania			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 					22. NAME AND ADDRESS OF FACILITY Hines-Rinaldi Funeral Home 11800 New Hampshire Avenue Silver Spring, Maryland 20904							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.										Approximate interval Between Onset and Death 30MINUTES		
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CEREBRAL INFARCT												
DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST												
b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												
					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			28. DATE OF INJURY (Month, Day, Year) 28a. 4/20			28b. TIME OF INJURY M 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURED
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. 4/20			28c. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28d. Location			28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, In my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER D33700			29d. DATE SIGNED (Month, Day, Year) ► June 14, 1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ted E. Howe, M. D. 18100 Slade School Road Sandy Spring, Maryland 20860												
31. DATE FILED (Month, Day, Year) JUN 16 1995		32. REGISTRAR'S SIGNATURE 										



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

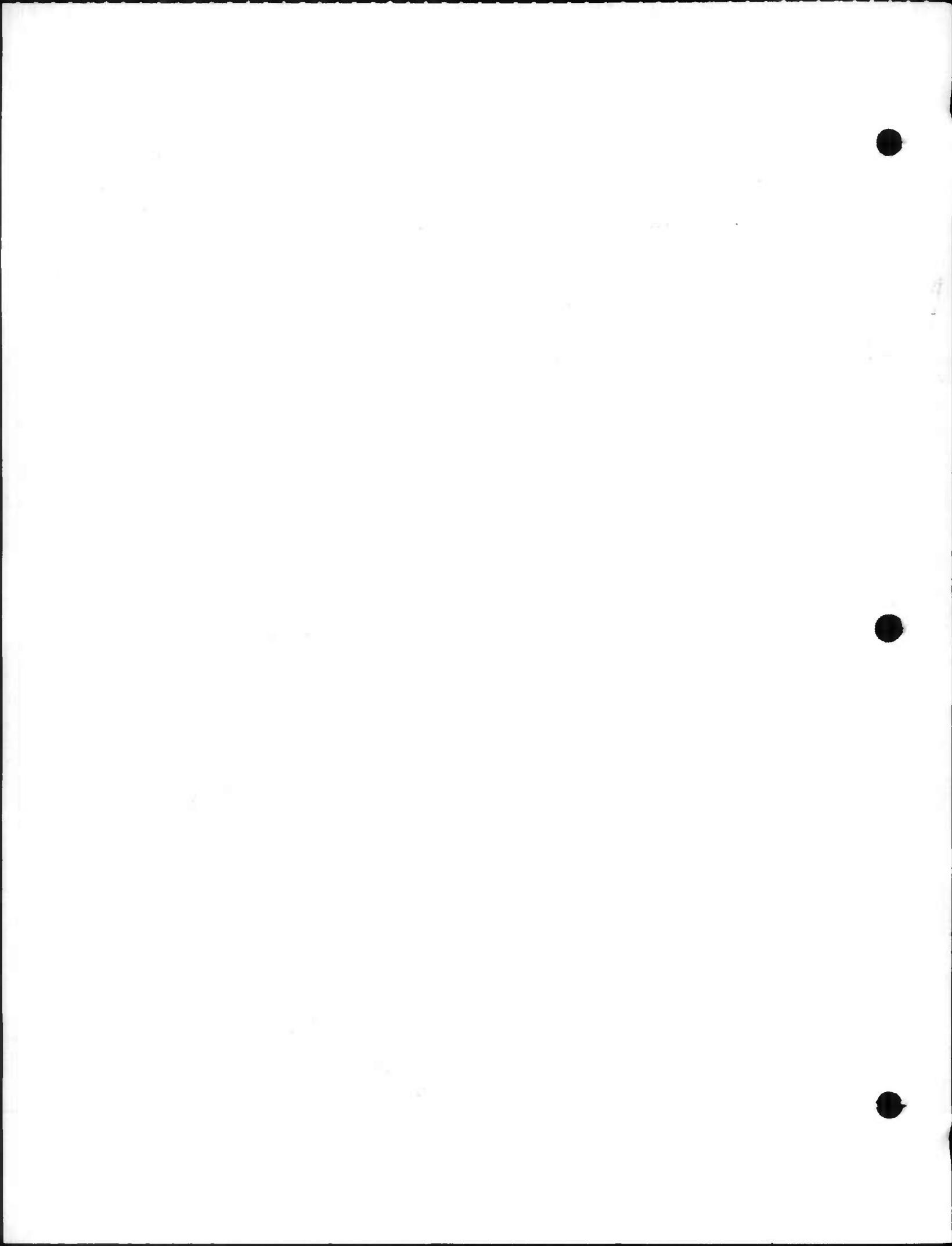
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.				
1. DECEDENT'S NAME (First, Middle, Last)			HERMAN B. HOGGARD							2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 6:45 PM				
4. SOCIAL SECURITY NUMBER 246-30-1056			5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 11/30/25		8. BIRTHPLACE (State or Foreign Country) N. Carolina			
9a. FACILITY NAME (If not institution, give street and number) 4672 American Corners Road			9b. CITY, TOWN OR LOCATION OF DEATH Federalsburg							9c. COUNTY OF DEATH Caroline						
10a. STATE Maryland			10b. COUNTY Caroline		10c. CITY, TOWN OR LOCATION Federalsburg							10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 4672 American Corner Road			10f. ZIP CODE 21632							10g. CITIZEN OF WHAT COUNTRY? United States						
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Sixth			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Paving Contractor			16b. KIND OF BUSINESS/INDUSTRY Construction										
17. FATHER'S NAME (First, Middle, Last) Gilliam Hoggard			16. MOTHER'S NAME (First, Middle, Maiden Surname) Bernice White													
19a. INFORMANT'S NAME (Type/Print) Mrs. Dorothy Hoggard			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4672 American Corner Rd., Federalsburg, MD													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Veterans			DATE 6-7		20c. LOCATION — City or Town, State Federalsburg, MD								
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Michael F. Eskow			22. NAME AND ADDRESS OF FACILITY Frampton-Hawkins-Eskow Funeral Home PO Box 43, Federalsburg, MD 21632													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Small cell lung Cancer DUE TO (OR AS A CONSEQUENCE OF):												Approximate Interval Between Onset and Death 1/2 years				
b. _____ DUE TO (OR AS A CONSEQUENCE OF):																
c. _____ DUE TO (OR AS A CONSEQUENCE OF):																
d. _____																
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>																
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED						
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																
29b. SIGNATURE AND TITLE OF CERTIFIER James Sides MD			29c. LICENSE NUMBER D31376			29d. DATE SIGNED (Month, Day, Year) ► 6-7-95										
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) James Sides 920 Market St Denton MD																
31. DATE FILED (Month, Day, Year) JUN 7 1995			32. REGISTRAR'S SIGNATURE J. Madison-Pendall													



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

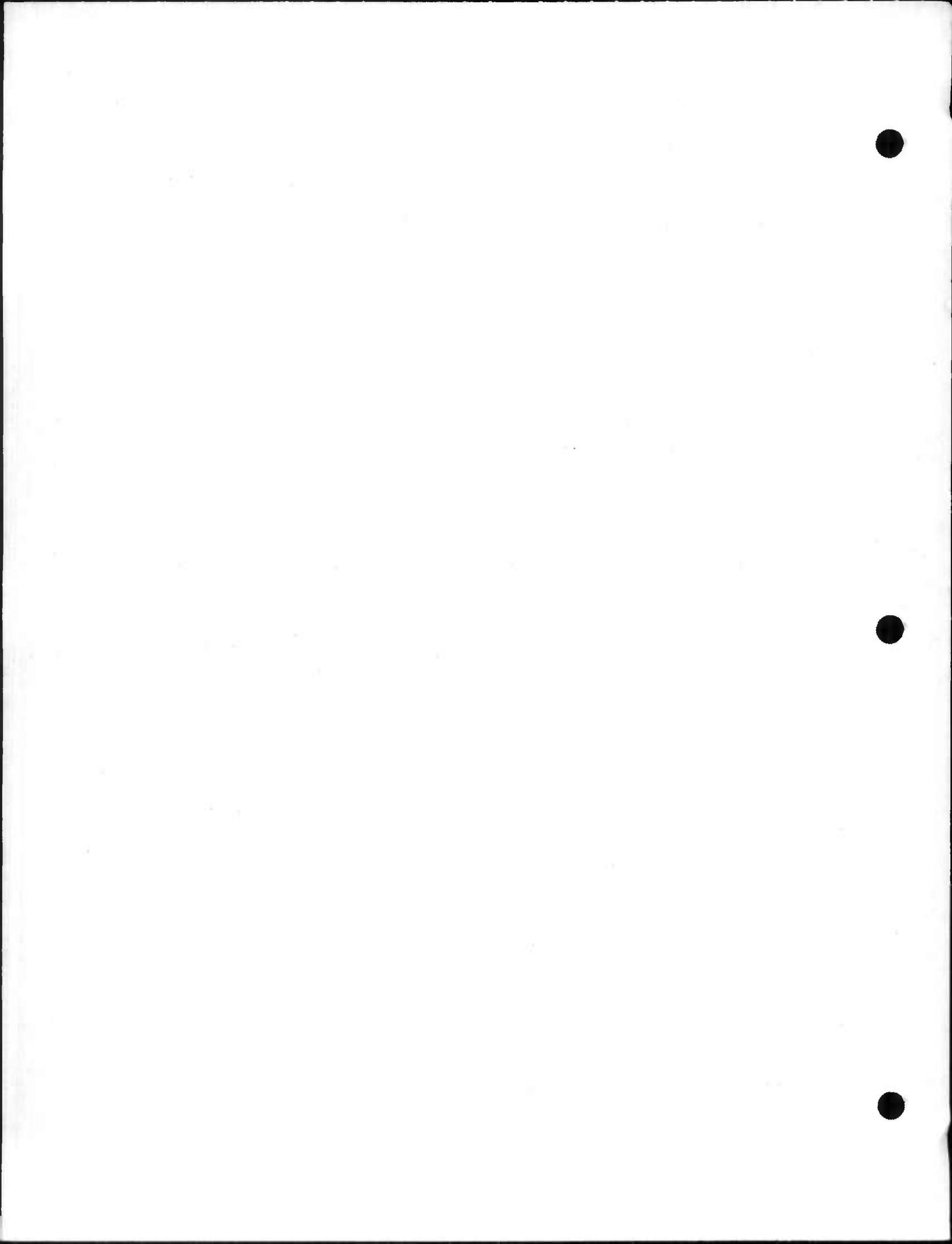
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE Enzie Gardner Harshman, Sr. CERTIFICATE OF DEATH												REG. NO.							
1. DECEASED'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH						
Enzie Gardner Harshman, Sr.												June 20 1995	0115 AM						
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)						
226-03-3162		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		86 YRS.		MONTHS		DAYS		HOURS MIN.		April 28, 1909	Maryland						
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH						9c. COUNTY OF DEATH							
Washington County Hospital						Hagerstown						Washington							
RESIDENCE OF DECEASED																			
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION						10d. INSIDE CITY LIMITS?									
Maryland		Washington		Hagerstown						<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
10e. STREET AND NUMBER						10f. ZIP CODE						10g. CITIZEN OF WHAT COUNTRY?							
18347 College Road						21740						USA							
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF NARVICAN ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify:													
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		13 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		14. RACE — American Indian, Black, White, etc. Specify:											
15. DECEASED'S EDUCATION (Specify only highest grade completed)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY															
Elementary/Secondary (0-12) 12		College (1-4 or 5+) truck driver		commercial trucking															
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)													
Daniel Oscar Harshman						Susan Emma Weller													
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)													
Phyllis Jean Hanna						17434 Virginia Avenue Hagerstown, Maryland 21740													
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)						20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)						DATE							
Rest Haven Cemetery												6/22							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gerald N. Minnich</i>						22. NAME AND ADDRESS OF FACILITY Gerald N. Minnich 305 N. Potomac Street Funeral Home Hagerstown, Maryland													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →												7 days							
a. <i>Acute Cerebral Vascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):																			
b. <i>Atherosclerotic Vascular Disease</i> DUE TO (OR AS A CONSEQUENCE OF):																			
c. _____ DUE TO (OR AS A CONSEQUENCE OF):																			
d. _____																			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes Mellitus Type II Probable lung carcinoma COPD HBP</i>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN												24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)																	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide												28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
												28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29c. LICENSE NUMBER <i>D 23815</i>										29d. DATE SIGNED (Month, Day, Year) <i>► 6/20/95</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>19414 D Leitersburg Pike, Hagerstown, Md 21742</i>																			
31. DATE FILED (Month, Day, Year) <i>JUN 2 1995</i>		32. REGISTRAR'S SIGNATURE <i>Julia Gardner Harshman</i>																	

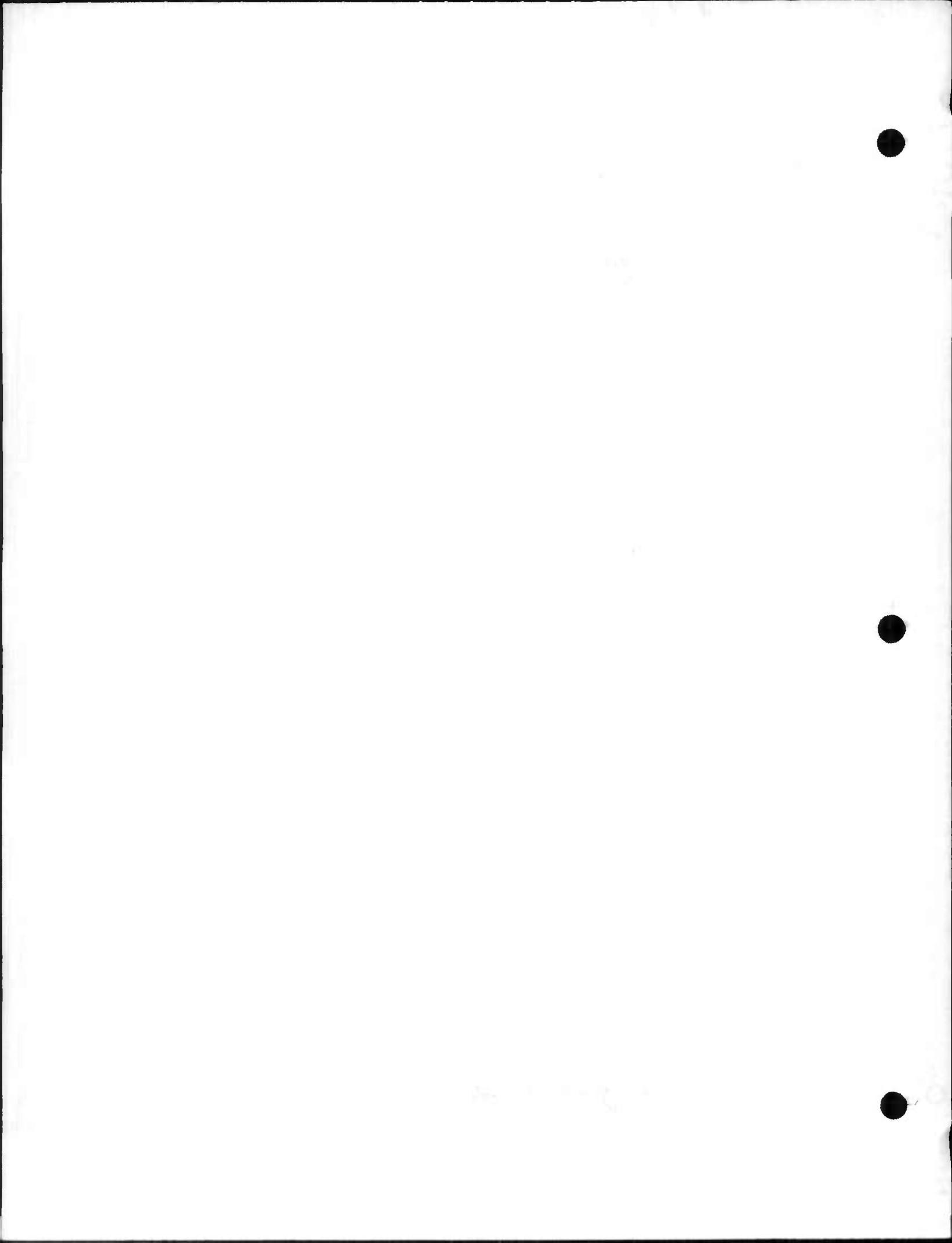


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the attending physician and completely filed in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.			
1 - STATE REGISTRAR												95 19498			
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH	3. TIME OF DEATH		
SUSAN Hamlin												MONTH June	DAY 4	YEAR 1995	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)					
158-32-4289		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	50 YRS.	MONTHS	DAYS	HOURS	MIN.	Month, Day, Year 11-9-1944		NEW YORK					
9a. FACILITY NAME (If not institution, give street and number)												9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
PENINSULA REGIONAL MEDICAL CENTER												SALISBURY		WICOMICO	
RESIDENCE OF DECEDENT															
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS?			
MD.	WICOMICO			MARDELA SPRINGS								<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
23626 BLUEBIRD LANE				21837				U.S.A.							
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify: WHITE									
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		Specify:									
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY							
Elementary/Secondary (0-12) 9		College (1-4 or 5+)		SALES CLERK				STORE							
17. FATHER'S NAME (First, Middle, Last)								18. MOTHER'S NAME (First, Middle, Maiden Surname)							
ELTON PHILLIPS								ADELE CRISFIELD							
19a. INFORMANT'S NAME (Type/Print)								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
LAURIE PARKS								2 WOODSIDE DRIVE, DELMAR, DELAWARE 19940							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE		20c. LOCATION — City or Town, State					
				DOWNING CEMETERY				6/8		OAK HALL, VA.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David C. Bounds</i>								22. NAME AND ADDRESS OF FACILITY							
								BOUNDS FUNERAL HOME, SALISBURY, MD.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Lymphoma												one yr			
DUE TO (OR AS A CONSEQUENCE OF):															
b. [empty]															
c. [empty]															
d. [empty]															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNCERTAIN <input type="checkbox"/>															
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)				OTHER:									
		Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
Natural Accident Suicide Homicide		Pending Investigation Could not be determined													
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. One (1) <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David C. Bounds, MD</i>												29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
												D 26278		► 6-4-85	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
David C. Bounds, MD 145 E. Carroll St. Salish, MD 21801															
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE													
JUN 07 1995		John J. Anderson, Registrar													



95 19499

DIVISION OF VITAL RECORDS, P.O. BOX 68760 BALTIMORE, MARYLAND 21215-0020

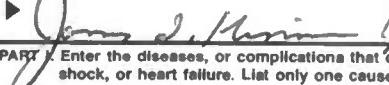
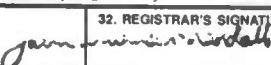
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

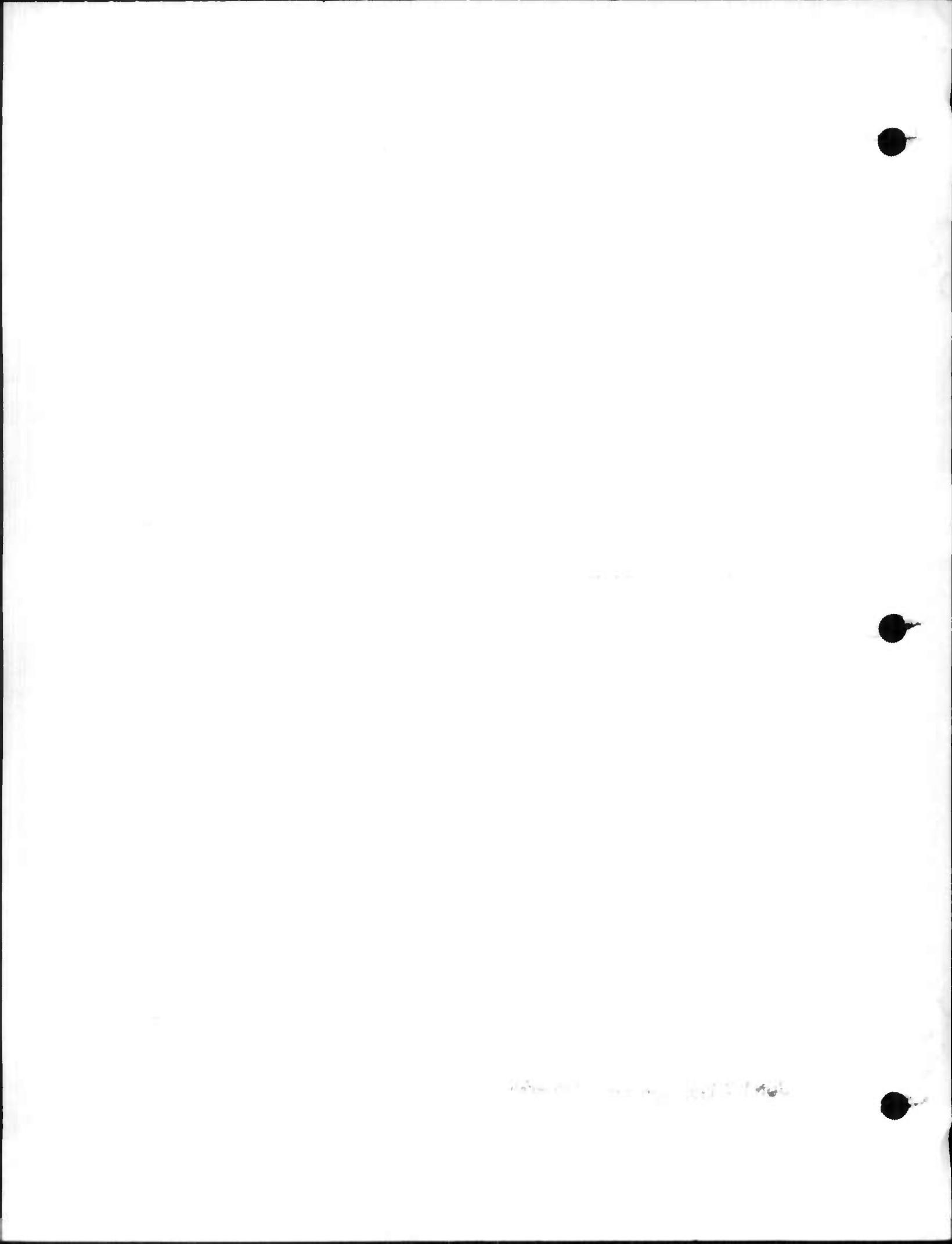
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)												2. DATE OF DEATH MONTH DAY YEAR	3. TIME OF DEATH
HOWARD I. Horseman Sr.												JUNE 9, 1995	0729 M
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				7. DATE OF BIRTH (Month, Day, Year)	8. BIRTHPLACE (State or Foreign Country)
215-26-5300		1 <input type="checkbox"/> M 2 <input type="checkbox"/> F		69 YRS.		MONTHS		DAYS		HOURS MIN.		Sept. 13, 1925	Maryland
9a. FACILITY NAME (If not institution, give street and number) PENINSULA REGIONAL MEDICAL CENTER												9b. CITY, TOWN OR LOCATION OF DEATH	9c. COUNTY OF DEATH
SALISBURY												WICOMICO	
RESIDENCE OF DECEDENT													
10a. STATE	10b. COUNTY			10c. CITY, TOWN OR LOCATION								10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
Maryland	Somerset			Deal Island									
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?					
23420 Fisher Road				21821				U.S.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES World War II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
1 Elementary/Secondary (0-12)		College (1-4 or 5+)		15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Engineer		16b. KIND OF BUSINESS/INDUSTRY Delmarva Power & Light					
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Howard Horseman						Fonzie Webster							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)				20c. LOCATION — City or Town, State					
Mrs. Betty J. Horseman				23420 Fisher Rd, Deal Island, Md. 21921				6/11 Chance, Maryland					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				DATE					
Rock Creek Cemetery								20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  M00295												22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, Md. 21853	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease													
DUE TO (OR AS A CONSEQUENCE OF):													
{ b. _____ c. _____ d. _____													
DUE TO (OR AS A CONSEQUENCE OF):													
DUE TO (OR AS A CONSEQUENCE OF):													
DUE TO (OR AS A CONSEQUENCE OF):													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Diabetes Mellitus												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>													
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Death 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or town, State)											
29e. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D 2910 5				29d. DATE SIGNED (Month, Day, Year) ► 6/9/95							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Christian J. Huddleston MD 106 Milford St., Salisbury MD 21801													
31. DATE FILED (Month, Day, Year) JUN 12 1995		32. REGISTRAR'S SIGNATURE 											



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last)											95 1950	
MARILYN F. HOOD												
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2. DATE OF DEATH MONTH DAY YEAR		3. TIME OF DEATH 0323 M		
216-28-8114		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	62 YRS.	MONTHS	DAYS	HOURS	MIN.	June 5, 1995				
9a. FACILITY NAME (If not institution, give street and number)											7. DATE OF BIRTH (Month, Day, Year) Sept. 14, 1932	
PENINSULA REGIONAL MEDICAL CENTER											8. BIRTHPLACE (State or Foreign Country) Virginia	
9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY											9c. COUNTY OF DEATH WICOMICO	
RESIDENCE OF DECEDENT												
10a. STATE	10b. COUNTY	10c. CITY, TOWN OR LOCATION			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
Maryland	Somerset	Westover										
10e. STREET AND NUMBER 7278 River Road					10f. ZIP CODE 21871		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H. S. Graduate		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Employee			16b. KIND OF BUSINESS/INDUSTRY Mrs. Paul's Kitchens							
17. FATHER'S NAME (First, Middle, Last) Clarence Pruitt					18. MOTHER'S NAME (First, Middle, Maiden Surname) Ada Parks							
19a. INFORMANT'S NAME (Type/Print) Sherman L. Hood (Husband)					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7278 River Road - Westover, MD 21871							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Springhill Memory Gardens-6/8/95			DATE		20c. LOCATION — City or Town, State Hebron, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► Robert H. Bradshaw, Jr.											22. NAME AND ADDRESS OF FACILITY Bradshaw & Sons Funeral Home 306 W. Main St. - Crisfield, MD 21817	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) →											Approximate Interval Between Onset and Death 6 MONTHS	
a. END STAGE CHRONIC BRONCHITIS DUE TO (OR AS A CONSEQUENCE OF):												
b. _____ DUE TO (OR AS A CONSEQUENCE OF):												
c. _____ DUE TO (OR AS A CONSEQUENCE OF):												
d. _____												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
DID TOBACCO USE CONTRIBUTE TO CAUSE OF DEATH YES <input type="checkbox"/> NO <input type="checkbox"/> UNCERTAIN <input type="checkbox"/>												
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one)			27. MANNER OF DEATH							
		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			OTHER:							
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)			28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			28f. LOCATION (Street and Number or Rural Route Number, City or town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER Akwasi Appau		29c. LICENSE NUMBER D44061			29d. DATE SIGNED (Month, Day, Year) ► 06-05-1995							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Akwasi Appau 540 RIVERSIDE DRIVE SUITE 4 SALISBURY												
31. DATE FILED (Month, Day, Year) JUN 8 1995		32. REGISTRAR'S SIGNATURE John A. Bradshaw										

2000 1970 1980

1990 2000 2010